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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 55 poorly - has been heard x3 screaming & crying for no apparent reason..." *2/21/06 at 3:30 am - "Cont. [continues] ABT for UTI...foley catheter patent of clear yellow urine [with] much white sediment..." *2/21/07 at 3:15 pm - "Called to [check] [resident #2]. She was being taken to room. Yelling & cursing. Chin is quivering [illegible word] she denies being cold. Put to bed [with] mechanical lift and applied O2. SATS [saturation] previous to this were 63%. SATS 71% on O2 at 2L/min [liters per minute], [increased] O2 to 3L [liters] but when she relaxed SATS dropped back to 68%...O2 up to 96% on 4L. Turned O2 to 3 1/2L/min. BP [blood pressure] 132/80, P [pulse] 119, R [respirations] 24, T [temperature] 101.9 [degrees Fahrenheit]. Noted Expirational wheezing in [right] lung only. Continues to deny pain...T.C. [telephone call] to [physician] per pager." *2/21/06 at 3:50 pm - "Received order to transfer to [hospital] ER for evaluation." A History and Physical, dated 2/22/06, documented the resident was admitted to the hospital due to a urinary tract infection and reduced oxygen saturations. Information provided by the facility on 7/31/06 documented the following: *"3/02/06- Urine positive for enterococcus treated with Zosyn changed to Augmentin. Repeat UA order in one week." *"5/03/06- Started antibiotics for UTI this am.	F 315		

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F 315	Continued From page 56 Urine clear amber with small blood clots." The physician recapitulation [RECAP] orders, dated July 2006, documented the following orders in regards to catheter care: *"S/P [suprapubic] cath[eter] care Q [each] shift." *"[change] S/P cath q [each] month, place 18 French next time then 20 French after that [and] [with] each catheter change irrigate cath [with] 500 cc [cubic centimeters] GU irrigation [with] each cath [change]." The treatment sheet, dated July 2006, addressed the information contained on the resident's RECAP but did not address specific issues regarding routine catheter care or prevention of urinary tract infections. On 7/28/06 at approximately 11:45 am, the resident was observed during the provision of suprapubic catheter care. The LN was observed to wash her hands and apply gloves before beginning the resident's care. The LN was observed to remove the old dressing and was not observed to change into clean gloves before continuing catheter care. Wearing contaminated gloves, the LN used a pre-moistened piece of gauze to clean around the stoma site. While cleaning around the stoma site, the LN was observed to wipe towards the stoma site with her gauze as opposed to wiping away from it. The LN used the gauze to dab around the stoma site in a circular fashion. After folding the contaminated portion of the gauze into her gloved hand, she repeated the dabbing motion with a clean portion of the same piece of gauze, again wiping towards	F 315		

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the stoma site. When the LN had completed cleansing the site, the LN discarded the contaminated gauze and picked up the clean dressing with her contaminated glove. The LN then applied the dressing to the resident's stoma site. The LN was not observed to cleanse the catheter tubing before applying the clean dressing.

According to Nursing Interventions & Clinical Skills (Elkin, Perry, Potter 2000, p. 829), when caring for a suprapubic catheter care and to prevent infection, an LN should:

*"Remove old dressing and place dressing and gloves in bag."

*"Put on sterile gloves, assess insertion site and patency of catheter."

*Maintaining sterility, clean site by swabbing in circular motion starting closest to the catheter site and continuing in outward widening circles for approximately 2 inches (5 cm [centimeters])..." The LN is instructed to perform this step as many times as needed to cleanse the site. The authors note this procedure "follows principle of sterile technique to move from area of least contamination to area of most contamination....Take one gauze pad moistened in antiseptic solution and cleanse catheter from proximal to distal."

An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #2's care plan and the prevention of UTIs. The DON noted that urinary tract infections were common in residents who were catheterized

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F 315	Continued From page 58 but did not address what the facility had in place regarding preventative measures for residents at risk. The DON and RCMs acknowledged the specific care plan discussed did not address the prevention of UTIs. They noted catheter care was documented on the resident's monthly treatment sheet. The facility failed to appropriately assess a resident who had a history of UTIs and pyelonephritis, identify she was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff failed to practice effective infection control measures during suprapubic catheter care to reduce the risk of infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 2. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The resident had a suprapubic catheter due to a neurogenic bladder. The most recent MDS, dated 6/5/06, documented the resident was totally dependent on staff for bathing, toileting, and personal hygiene. The care plan, dated 5/23/06, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the	F 315		

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F 315	Continued From page 59 resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician RECAP orders, dated July 2006, documented the following orders in regards to the resident's catheter: *5/23/06 "Supra Pubic Cath[eter] care q [every] shift DX [diagnosis]: Neurogenic bladder." *5/23/06 "Change Supra Pubic Cath Q month 20 French w/30 cc balloon." The treatment sheet, dated July 2006, documented "Super [sic] Pubic Cath Care Q Shift" and "Change Super [sic] Pubic Q Month 20 French W/30 CC Balloon." Information provided by the facility on 7/31/06 revealed the following history related to urinary tract infections: *10/19/05 The resident was admitted to the facility following hospitalization for urosepsis. Prior to the hospitalization, the resident had been living at home. *12/07/05 Temperature of 100 [degrees Fahrenheit], bloody drainage from suprapubic catheter. Started on Macrobid and urinalysis (UA) with culture and sensitivity obtained. The results revealed Escherichia coli (E-coli). *12/22/05 UA obtained due to "SP [suprapubic] trauma with increased temp..." The results revealed Pseudomonas Aeruginosa. *3/9/06 "H & P [history and physical] states urine	F 315		

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appears infected with specific gravity > [greater than] 1030, 1+ proteinuria, trace ketones, 3+ occult blood, 3+ leukocyte esterase, + nitrites, 5-10 RBC's [red blood cells], 25-50 WBC [white blood cells], many bacteria, moderate yeast. Impression: Acute sepsis...suspect early sepsis, either from leg wound or from UTI."

A physician's note, dated 6/23/06, revealed the resident, "was hospitalized on 5/17/06-5/23/06 for a urinary tract infection with candida albicans."

The resident was observed during wound and peri care on 7/25/06 at approximately 11:10 am. The LN washed her hands and donned gloves before cleaning and covering the stage II pressure ulcer on the resident's right ischium. The LN was not observed to wash or sanitize her hands or change her gloves before proceeding to care for the stage IV pressure ulcer on the resident's left ischium. According to documentation, the resident had recently been on isolation precautions due to MRSA infection in the stage IV pressure ulcer. The LN cleansed and covered the wound. During the procedure, she reached into her pocket with her contaminated gloves to pull out a pair of scissors and a sharpie pen. The LN was observed to place the sharpie back into her pocket handling it with her contaminated gloves. After completing wound care, the LN proceeded to assist the CNA in repositioning the resident. The resident had a bowel movement and required clean up and peri care. The LN was not observed to wash or sanitize her hands after the wound care and before getting herself and the CNA a clean pair of gloves before they began the peri care. During the procedure, a large amount of feces came into

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contact with the top cover of the resident's air bed. The CNA and LN wiped the area and noted they would change the cover after getting the resident up for lunch in about an hour or so. After completing peri care and dressing the resident in clean clothing, staff were observed to place the resident directly on top of the contaminated area of the air bed with his clean clothing in direct contact with the contaminated surface.

An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #1 and #2's care plans and the prevention of UTIs. As stated above, the DON noted that urinary tract infections were common in residents who were catheterized but did not address what the facility had in place regarding prevention measures for residents at risk. The DON and RCMs acknowledged the specific care plans discussed did not address the prevention of UTIs. They noted catheter care was documented on the residents' monthly treatment sheet. When questioned as to what preventative measures the facility was taking to UTIs for resident #1, staff stated they used a leg bag on the resident at times to prevent the catheter tubing from touching the floor and becoming contaminated as well as following facility protocol for suprapubic catheter care. After the interview was concluded, a RCM presented the surveyor with an undated handwritten list that contained the following information: Vitamin C 500 milligrams twice a day, Suprapubic catheter care every shift, using leg bag for catheter when resident is out of bed, and Minocin 100 milligrams twice a day. According to the resident's physician RECAP, dated July 2006, the resident had been prescribed Minocin on 5/23/06 due to the MRSA infection in his pressure

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F 315	Continued From page 62 ulcer. The facility failed to appropriately assess a resident who had a history of UTIs and urosepsis, identify he was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff practiced poor infection control during wound and peri care on a resident with known MRSA infection. This failed practice resulted in harm to the resident who was hospitalized in May 2006 with a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 3. Resident #8 was originally admitted to the facility on 1/26/1995, and readmitted on 3/25/04, with diagnoses including paraplegia, schizophrenia, neurogenic bladder, UTI, status post venous thrombosis and cellulitis of the buttocks. The most recent quarterly assessment, dated 5/26/06, documented the resident had severely impaired cognition, was totally dependent for all care and had a suprapubic catheter in place. The care plan, dated 3/25/04, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician's RECAP, dated July 2006, documented "Supra pubic cath care q shift" and "Change S/P [Suprapubic] cath PRN 18 FR	F 315		

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F 315	Continued From page 63 [French]/30CC Balloon DX [diagnosis]: Neurogenic Bladder (Change Q MO [every month]." An order, dated 7/19/06, documented, "7/19/06 Ampicillin 500 mg [one] po [by mouth] BID [twice a day] x 14 days. Dx [diagnosis] UTI." Results of a urine culture, dated 6/29/06, documented the presence of the following organisms: Pseudomonas Aeruginosa, MRSA, and Enterococcus Faecalis. Results of a urine culture, dated 7/13/06, documented the presence of the following organisms: Pseudomonas Aeruginosa and Enterococcus Faecalis. On 7/28/06 at 11:00 am, the surveyor observed a LN change the dressing to a pressure sore on the resident's buttocks. The LN obtained the clean dressings from a cart, placed the clean supplies on the resident's bedside table without cleaning the table or providing a barrier between the clean supplies and the contaminated over bed table. The LN gloved, removed the dressing, cleansed the wound and placed the contaminated dressings on the overbed table. Then, using the hand with the contaminated glove, adjusted the lighting with the light switch and replaced the clean dressing. CMS guidance addresses urinary tract infections and follow up of UTIs as follows: "A long term indwelling catheter (>2 to 4 weeks) increases the chances of having a symptomatic UTI and urosepsis. The incidence of bacteremia is 40 times greater in individuals with a long term indwelling catheter than in those without one...Recurrent symptomatic UTIs in a	F 315		

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F 315	Continued From page 64 catheterized or noncatherized individual should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling in accordance with accepted practices...to re-evaluate the techniques being used for perineal hygiene and catheter care...the facility should demonstrate that they: Employ standard infection control practices in managing catheters and associated drainage system; Strive to keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder...; Assess for fluid needs and implement a fluid management program...based on those assessed needs." The facility failed to identify residents at risk for UTIs, develop care plans addressing preventative measures and demonstrate appropriate infection control practices during wound and catheter care. 4. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke] hematoma of left leg, sacral stenosis, and dementia. At the time of admission, the resident had a Foley catheter in place. The catheter was discontinued on 5/1/06 per documentation in nursing notes. An MDS, dated 5/9/06, documented the resident was severely impaired in cognition, was totally dependent on staff for most ADLs including toilet use and that she was frequently incontinent of urine. An "Assessment for Bowel & Bladder Training" dated 4/28/06, documented the following in the "Bladder Continence Pattern" section: "N/A [not applicable]" and the box "Frequently incontinent	F 315		

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(daily with some control)" was marked. The form noted the resident had a Foley catheter that had been inserted on 4/23/06. The "Symptoms", "Evaluation", "History", and "Plan for Management" sections of the form were left blank.

The care plan was not dated but documented an admission date of 4/28/06. The care plan addressed toileting in problem 1, "ADL/REHAB" and documented the resident was incontinent of bowel and urine and had a Foley catheter in place. One portion of the care plan that was undated documented the resident "pulls on catheter tubing" and had a "UTI."

An "Assessment Summary", dated 5/11/06, documented "Res[ident] toilets [with] assist of 2 [and] is dependent for peri care, proceed to care plan."

An interview was conducted with the DON and 3 RCMs on 7/27/06 at 12:35 pm. The DON acknowledged a bladder assessment had not been completed on the resident after the catheter was removed on 5/1/06. She stated that she would have to look at OT (Occupational Therapy) notes as that was within their scope of practice and they should have assessed her. She stated, "...[the resident] resists a lot, [the resident] is very demented..." She acknowledged the facility did not assess the voiding patterns of the resident.

The DON was interviewed again on 7/27/06 at 3:10 pm , regarding an updated bladder assessment. She stated, "We did assess, we just didn't re-assess after the Foley was removed." She indicated the resident was incontinent due to

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F 315	Continued From page 66 dementia and stated that if the facility toileted everyone, they wouldn't have time for other cares. The facility did not ensure a resident was accurately assessed regarding urinary incontinence to ensure she received the appropriate services to restore or improve normal bladder function to the extent possible. The resident was not re-assessed after her Foley catheter was removed 3 days after she was admitted to the facility. The facility had no documentation on the bladder assessment referencing the resident's prior history of incontinence, voiding patterns, medication review in reference to incontinence, patterns of fluid intake, or other comprehensive assessment information pertinent to urinary incontinence. The resident was not care planned for a specific toileting program for the prevention of urinary tract infections related to incontinence issues. The resident was assessed as incontinent per the MDS of 5/9/06 and documentation from the July "CNA Flow Sheet..." indicated she was incontinent at the time of the survey. 5. Resident #7 was admitted to the facility on 7/21/06 with the diagnoses of squamous cell tongue cancer, hypothyroidism, chronic aspiration, stage III pressure ulcer, fractured femur, and aspiration pneumonia. An "Admission Nursing Assessment", dated 7/21/06, documented under abdomen/bowel/bladder, "Foley: Size/Type & Dx [diagnoses] for use Fx [fractured] hip. Dr [doctor] to remove in one week." A transfer physician order dated 7/13/06	F 315		

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F 315	Continued From page 67 documented, "Discontinue Foley per [physician name] at follow-up appointment..." Resident #7's current care plan documented that the resident had a commode at his bedside. Resident #7's CNA flow sheets for July documented that the resident used the bed side commode for toileting. On 7/27/06 at 3:15 pm, resident #7 was interviewed. He indicated with the motion of his head and his hands that he used his bed side commode for bowel movements. On 7/26/06 at 9:05 am, the DON indicated that resident #7 was admitted with a Foley catheter and and was not sure why it was in place but would find out and let the surveyor know. Several hours later the DNS provided the surveyor with a physician telephone order. A physician's telephone order dated 7/26/06 documented, "Foley catheter indicated r/t [related to] hypoxia [and] respiratory distress [with] exertion..." Resident #7 was admitted with a Foley catheter and there was no documentation indicating any medical condition that warranted the continued use of an indwelling catheter. The facility failed to ensure that a resident with a catheter was assessed and evaluated to determine the need for the catheter.	F 315		

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F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure the environment remained free of accident hazards. Unlocked chemicals were found in 1 of 2 shower rooms on the 200 hall and in the soiled utility room on the 100 hall. Skin tear hazards were observed in 4 of 4 shower rooms. A resident was at risk for a fall when he was observed lying on an air bed with one side rail down. This affected 1 of 11 sample residents (#7) and had the potential to affect all residents who used the shower rooms or who may wander in to the soiled utility room. Findings include: 1. Unlocked Chemicals a. During the environmental inspection on 7/26/06 at approximately 3:25 pm, the first shower room from the nurses' station on the 200 hall was inspected. A cupboard door was open with the key in the door and a spray bottle of disinfectant cleaner was on a shelf. The maintenance man immediately locked the cupboard and put the key out of sight. b. The soiled linen room was inspected at approximately 3:46 pm. The room was unlocked and the cupboard under the sink contained a bottle of bleach that was approximately 1/3 full and a 1/2 full bottle of disinfectant. Another cupboard contained a 1/2 full bottle of Spot Gone carpet cleaner.	F 323	**Corrective Action:** **1.** All chemicals in the shower rooms and soiled utility rooms were placed in locked cabinets. **2.** The tile in the 200 Hall shower room has been repaired. **3.** The edges of the shower room doors have been repaired. **4.** Resident #3 has been informed of the safety hazards related to the non-use of side rails while utilizing a specialty air bed and the manufacturer's recommendations. He understands that without the use of side rails he could slide from mattress and be injured. He has accepted the use of side rails while in bed on a specialty mattress. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** The maintenance, housekeeping and nursing staff has been inserviced regarding the proper storage of chemicals and the requirement to keep the chemicals locked in a secured cabinet. **2.** Maintenance will complete weekly environmental rounds to identify and complete repairs and assure proper chemical storage is maintained. **3.** Nursing staff to be inserviced on standard practice and manufacturers' recommendations to have side rails up while resident is in bed utilizing a specialty air mattress for safety. **4.** A nursing order to the resident's Treatment Administration Record (TAR) to "Monitor Side Rails to be up at all times while resident is in bed on Air bed/ mattress each shift" Continued on p. 70	

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F 323	Continued From page 69 2. Skin Tear Hazards a. During the environmental inspection on 7/26/06 at approximately 3:25 pm, skin tear hazards were discovered in 4 of 4 shower rooms. In the first shower room from the nurses' station on the 200 hall, broken tile was observed on a 1/2 wall separating the shower stall from the rest of the room. The broken tile was at approximately ankle and calf level, contained sharp, jagged edges and presented a skin tear hazard to residents entering the shower. Four of 4 shower rooms in the facility had skin tear hazards on the outside of the entrance doors. Chunks of wood was missing at approximately the ankle and calf level and the doors were damaged and scarred approximately 3 feet up from the floor. These areas presented skin tear hazards to residents entering the shower rooms either on foot or via wheel chair. The edges of the doors contained sharp areas with wood slivers. The maintenance man was present and he indicated he would take care of the problem. 3. Resident #7 was admitted to the facility on 7/21/06 with the diagnoses of squamous cell tongue cancer, hypothyroidism, chronic aspiration, stage III pressure ulcer, fractured femur, and aspiration pneumonia. A "physical restraint/assistive device assessment/consent" form, dated 7/21/06, documented, "Restraint and/or assistive device utilized: side rails to maintain integrity of air	F 323	**Monitor:** **1.** Maintenance and Administrator to monitor environmental rounds to ensure compliance weekly. **2.** DNS to audit resident and Treatment Administration Record (TAR) for side rail utilization compliance on residents' using air beds/mattresses weekly and with Quality Assurance Review Committee.	9/2/2006

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F 323	Continued From page 70 mattress." On 7/26/06 at 10:00 am resident #7 was observed to be lying in bed with his left side rail up and the right side rail down. This observation continued for ten minutes. At this time the DNS was made aware of the observation. The DNS acknowledged that the side rail was down and indicated that it should be up because of his air mattress. At this time the surveyor asked the DNS for the residents air mattress manufacturer's recommendation for side rails and the DNS provided a copy. The Gaymar Plexus Air Express manufactures information on page 3, under safety precautions documented, "...Side Rails Must Be Used With The Plexus Mattress To Prevent Falls..." The facility did not ensure that residents were provided with an environment as free of accident hazards as possible.	F 323		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not	F325	**Corrective Action:** **1.** Resident #1 refers to the Plan of Correction for F-272, F-279, and F-309. Resident number 1 did have weekly weights taken and were in the residents clinical record along with the corresponding weight/nutrition at risk meeting assessments and notes located in the vital sign and weight section of the resident's clinical record. **2.** A significant change in status Minimum Data Set (MDS) will be completed to fully reflect the resident's current medical, functional, physical and psychosocial status. The resident's care plan will be revised accordingly to correspond to the MDS assessment data. Continued on p. 72	

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F 325	Continued From page 71 prevent unnecessary weight loss. This affected 1 of 11 sampled residents (#3). The lack of a complete assessment, specific care planning and accurate documentation of intake resulted a weight loss of 12 pounds or 8% in three weeks. The findings include: Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke], hematoma of left leg, sacral stenosis, dementia and history of peptic ulcer. Upon admission, the resident's weight was documented as 132 (pounds) and she was 5' 1-1/2 inches tall. The admission MDS, dated 5/9/06, indicated the resident was severely cognitively impaired and dependent in all ADL's. The resident required extensive assistance of one staff member to eat. The Nutritional Status RAP Module dated 5/11/06 documented that the resident needed extensive assistance with eating. The nursing RAP summary documented, "Res-[ident] at times is dependent for eating and will not feed herself. Needs assistance and cuing to eat and drink." The resident's care plan, dated 4/28/06, documented the following problem: "Nutritionally at risk R/T [related to] disease process." The short term goals included intake of over 75% of meals, no s/s [signs and symptoms] of dehydration, no significant weight loss." The documented approaches included: (1) Regular diet, nem [nutritional enhanced meals], small portions, (2) House supplement 4 ounces am, pm and HS [bedtime] (3) FEP [fluid enhancement program], (4) RD referral, (5) allow ample time to finish food and fluid, (6) encourage food and fluid intake and identify and cut food for resident.	F 325	**3.** The resident's family has reviewed the menu cycle from the dietary department with the dietary supervisor and has circled the food choices that they felt their mother, per her history would enjoy since the resident has dementia and is unable to state her food preferences. This is to assist in helping to increase the resident's food intake. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Refer to: F- 272, F-279. F-309. The interdisciplinary team members will be inserviced on weekly weight monitoring, assessment and documentation as well as the Minimum Data Set (MDS) process to assure accurate assessment, documentation and care planning by the Corporate Nurse Consultant. **2.** The Minimum Data Set (MDS) and Resident corresponding care plans will be reviewed weekly by the interdisciplinary team and the DNS for accuracy per the weekly Minimum Data Set (MDS) schedule. **Monitor:** **1.** Dietary Supervisor and DNS to monitor the obtaining of weekly weights and the documentation of weights obtained into the clinical record and any corresponding weight summaries or assessments required for weekly weight review for accuracy and completion. This includes reviewing and updating the residents' existing care plan as applicable. **2.** The Dietary supervisor and the DNS will monitor meal monitors for completion and accuracy weekly. This includes meal percentage consumed, meal replacement documentation and supplements as well as HS snacks.	9/2/2006

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F 325	Continued From page 72 The dietary assessment, dated 5/4/06, indicated the resident should have weekly weights. The weight summary documented the resident's weight on 4/28/06 as 132 pounds and on 5/18/06 as 120 pounds. This constituted a 12 pound loss in 3 weeks. The resident's "Meal Intake" records from May 1-18, 2006 revealed the following: The resident consumed an average of 35% of breakfast, 21% of lunch, and 21% of dinner. The documentation revealed the resident refused 8 meals in 18 days. On the days the resident refused a meal, or ate less than 50% of a meal, the house supplement was documented as taken only 3 times. There was no documentation to indicate whether or not she was offered an alternate choice. Snacks were documented as follows: AM snacks accepted 3 times, refused 10 times and not documented 5 times, PM snacks were documented as offered and accepted on May 11 and 12th with no other documentation, HS (bedtime) snacks were documented as offered and accepted on May 10 and 15th with no other documentation to show that snacks were offered on other days. The documentation on the meal monitor was inconsistent. The records indicated a lack of offering the house supplement to the resident and lack of documentation of any alternate foods or snacks offered to the resident. This made it difficult to determine the resident's actual intake. The resident's Weight Flow Sheet documented the following :	F 325		

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F 325	Continued From page 73	F 325		

"4/28/06, Admission weight 132 pounds, 5/3/06, Weight 134 pounds. Resident averages 18 % for breakfast, 35 % for lunch and 10 % for pm meals. Continue to monitor on weekly weights, 5/18/06, has lost 14 pounds since last week, meal intake averages 45% of breakfast 21% of lunch and 43 % of dinner. Report that resident had decreased independence in feeding self. Will request to add 2-3 finger foods and continue to monitor weekly weights."

Weekly weights were to be done and recorded; however, weights were only documented on admission (5/3/06) and on 5/18/06 (15 days later). It was during this period of time the resident lost weight.

The Dietary Assessment, dated 5/4/06, indicated the resident had some "negative behaviors" since admission, the resident was above IBW - [ideal body weight] and UBW [usual body weight] 123 pounds, but meal intake was poor, "Suspect weight will decrease. Will suggest regular, nem small portions diet, clarify Protein supplement to House supplement TID [three times a day] between meals. Monitor closely."

On 5/26/06, the Dietary assessment notes included the following: "Resident down 11 pounds (8%) since admission and was likely related to starting of Lasix 20 mgs given for 2 days on 5/11 and 5/12. Weight loss occurred between 5/11 - 5/18 so the present weight is closer to the usual body weight (the resident's current weight is 119 pounds)."

Review of the nurse's notes revealed the

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F 325	Continued From page 74 following documentation: *5/5/06, "Feeds self some of the time, assisted by staff when resident allows. Appetite poor." * 5/6/06, "To dining room for meals, feeds self but needs extensive assist also." * 5/7/06, "Refused to get up for lunch, no signs and symptoms of adverse reaction to increase Risperdal and Depakote." * 5/9/06 " No s/s [signs and symptoms] adverse reaction to increase in Depakote and Zyprexa". * 5/10/06, "Refused to get up for breakfast, did have a 100% shake." * 5/11/06, "Appetite poor." * 5/12/06 - "Resident returned from Dr's office ...received order for Narco 5/325- 1-2 q [every] four hours while awake... increase Depakote to 250 mgs q am, 500 mgs ... HS." * 5/14/06, "Feeds self in dining room, appetite poor." * 5/15/06, "Feeds self with some assist from therapy." An Occupational therapy evaluation completed 6/20/06, after the weight loss, indicated the resident's independence with eating was limited due to poor vision. On 7/24/06 at 12:55 pm the resident was observed in the dining room holding a cup. She could barely hold her head upright. The resident was very sleepy. She tipped her face forward and slightly tipped the cup to drink fluid. She was observed again in the dining room at 2:00 pm, dozing in the chair. She had eaten less than 25% of her meal. The CNA indicated the resident didn't eat much and starts throwing food to indicate she is through. On 7/25/06 at 8:20 am the resident	F 325		

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F 325	Continued From page 75 was observed sitting with her head on the dining table. The care plan did not include the resident's resistive behavior and poor vision, pain and medications i.e., Narco, Risperdal and Depakote, as factors placing her at risk for weight loss. After the weight loss the resident was placed in the restorative dining room on 5/19/06. The care plan was not individualized or revised as needed to reflect the various interventions tried by the staff to encourage the resident to eat or what action to take when the resident refused to eat. Alternate food choices the resident preferred were not included in the plan. The care plan was also not individualized to reflect the amount of assistance the resident required with eating. The initial care plan for nutritional risk had not been revised as of 7/28/06. Due to the lack of a complete assessment, specific care planning and complete accurate documentation of intake it could not be determined that the weight loss was unavoidable.	F 325		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility did not ensure 1 of 11 sample residents (#10) received proper care of the toenails. Findings include: Resident #10 was admitted 6/24/06 with diagnoses that included CVA [stroke] and dementia. Findings include: The admission MDS assessment, dated 7/3/06, indicated the resident's cognition was severely impaired and she was dependent for all care. The resident's toenails were observed on 7/28/06 at 9:25 am. They were thick, long and rough. The LN with the surveyor during this observation, stated the facility did refer residents to a podiatrist but she did not know if this resident had been referred for nail care. No additional information regarding a referral was provided. According to "Quality of Care in the Nursing Home," 1997, severely hypertrophic nails can	F 328	**Corrective Action:** Resident #10 has had toenails trimmed and filed by facility licensed nurse on 07/28/06. DNS spoke with the resident's family member who is the Power of Attorney for Healthcare (POA) regarding further follow up with Podiatry services. The family member refused Podiatry for financial reasons and more importantly, that their mother is at end of life and they fear that Podiatry services will be more invasive and cause pain and discomfort which they do not want. The facility licensed nurses will continue to trim and file the resident's toenails weekly and document on the resident's Treatment Administration Record (TAR) that this has been completed. The licensed nurses will also monitor for pain and discomfort during this time and discontinue if any discomfort occurs. The resident wears heel lifts to pad and protect her feet and these protect her toes from injury. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Nursing staff will be inserviced on identification of nail care needs and the completion of nail care to be done in a timely manner. **2.** An Audit has been put in place to monitor nails daily for nail care needs. **Monitor:** DNS to monitor weekly for compliance and at Quality Assurance Committee.	9/2/2006

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F 328	Continued From page 77 cause nail bed ulcerations in the elderly.	F 328		
F 354 SS=D	483.30(b) NURSING SERVICES - REGISTERED NURSE Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of facility staffing schedules and staff interview, it was determined the facility did not ensure that a registered nurse (RN) worked 8 hours each day for 4 of 21 days reviewed (7/2/06, 7/3/06, 7/9/06, and 7/16/06). Also, the facility did not ensure the DON devoted full time to supervising and managing the nursing department. This had the potential to affect all residents in the facility. The findings include: 1. Review of facility's "Three-week Nursing Schedule" and the as-worked schedules from 7/2/06 thru 7/22/06 revealed no RN coverage on 7/2/06, 7/3/06, 7/9/06, and 7/16/06.	F 354	**Corrective Action:** **1.** The facility staffing coordinator will continue to complete the monthly licensed staffing schedule with full DON review daily to assure RN staffing compliance needs are met. An additional part-time RN has been hired to assure compliance. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.**Staffing system remains the same with staffing coordinator scheduling the licensed staff but with the addition of daily DON oversight to assure daily RN staffing requirements are met. **2.** Staffing coordinator to review staffing schedule and scheduling needs at the 24 hour report process **Monitor:** Administrator to monitor weekly to assure compliance and at Quality Assurance Committee.	9/2/2006

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F 354	Continued From page 78 On 7/26/06 at 8:30 am, the facility's Administrator was interviewed. The Administrator indicated he had completed the staffing numbers for the three-week nursing schedule and acknowledged there was no RN coverage for 7/2/06, 7/3/06, 7/9/06, and 7/16/06. He also indicated that he thought that this was only a requirement if the census was 60 residents or above. 2. The DON was interviewed on 7/28/06 at 10:00 am. She stated she was responsible for social services since the social worker left one month ago. She also stated she oriented all facility staff including nursing and provided inservice with the help of the Resident Care Managers. She had trained staff to complete the MDS and was responsible for the accuracy of the completed MDS.	F 354		
F 367 SS=D	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on tray line observations and staff interview it was determined the facility did not ensure residents were provided with diets as prescribed by their physician. This affected 3 residents reviewed during tray line (#1, 9, 20). Findings include: 1. On 7/26/06 at 12:20 pm, during an observation of a noon tray line, the following observations occurred:	**F367**	**Corrective Action:** Residents #1, 9, and 20 have each had their diets reviewed by the dietary supervisor and alternative sources for adding protein replacements has been put into effect (milk sources). **Identification:** All resident's are identified as potentially being affected. **Systemic Changes:** Dietary supervisor has included alternative source to mixing protein powder into meals when menu does not have liquid source that is palatable when mixed with protein powder. (Milk source to be utilized) **Monitor:** Dietary supervisor to complete weekly audit to assure compliance with protein powder supplemental additions and review with Quality Assurance Committee.	9/2/2006

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F 367	Continued From page 79 a. Resident #1's tray was observed to only receive one scoop of protein powder and regular portions of protein when his diet card indicated that he was on a large protein diet and was to receive two scoops protein powder at each meal. Resident #1's July 2006 recapitulation orders documented, "large portions [with] 2 scoops protein power per tray." b. Resident #9, tray was observed to not receive any of the protein powder when her diet card indicated that she was to receive one scoop of protein powder at each meal. Resident #9's July 2006 recapitulation orders documented, "1 scoop protein per meal." c. Resident #20's, tray was observed to not receive any of the protein powder when her diet card indicated that she was to receive one extra protein at each meal. Resident #20's July 2006 recapitulation orders documented, "Add extra ounce protein w[ith]/tray". As each of the trays entered the tray cart, the surveyor stopped the delivery of the tray and the kitchen staff acknowledged that they had not added to extra protein to each of these trays. At this time the trays were corrected before they were delivered to the residents.	F 367		

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F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following areas: 1) food contact surfaces clean and sanitized, 2) food contact surfaces smooth and free of pits 3) possibly contaminated equipment in direct contact with food 4) non food contact surfaces clean and sanitized, 5) storage of bowls. This had the potential to affect 100 % of the residents who ate in the facility, including 10 of 11 sampled residents (#1-6 & #8-11). Findings include: 1. On 7/26/06 at 11:05 am, during an observation of food preparation, 8 out of 21 plastic coffee cups were observed to have a built up of residue on the inside of the cup and 6 out of 15 bowls were observed to have dried food debris on the inside of the bowl. At this time the dietary manager acknowledge this observation and indicated that they would get re-washed. *Chapter 4, subsection 601.11 of the 2005 Federal Food Code indicates,"(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. 2. On 7/26/06 at 11:05 am, during an observation of food preparation, 4 out of 21 plastic coffee cups and 2 out of 15 plastic bowls were observed	F 371	**Corrective Action:** **1.** Residents #1-6 and #8-11 that were affected had re-wash of bowls and cups during the survey. **2.** Dishes that were pitted were replaced immediately. **3.** The appropriate use of thermometer when testing food sources was completed by demonstration with dietary staff with return demonstration to assure compliance **4.** The fan in the kitchen was cleaned by maintenance **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** All dietary staff was inserviced on appropriate dish washing techniques to assure that no dried substances or residue is present. **2.** All dishes are to be monitored by the dietary supervisor for replacement if necessary if any pitting occurs. **3.** Dietary supervisor inserviced dietary staff on appropriate thermometer sanitizing procedures verbally and by demonstration. **4.** Cleaning of the fan has been placed on routine maintenance cleaning schedule. **5.** Dietary supervisor inserviced dietary staff on the requirement to cover the mixing bowl. **Monitor:** **1.** Dietary supervisor will Monitor thermometer sanitizing weekly for compliance **2.** Dietary supervisor will monitor all dishes replacement needs weekly **3.** Dietary Supervisor will monitor fan weekly for cleanliness. **4.** Dietary supervisor will monitor that mixing bowls are covered weekly	9/2/2006

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F 371	Continued From page 81 to have scratches, pits, and scoring on the inside food contact portion. The dietary manager acknowledged this observation and indicated that she had recently replace some of the bowls and cups. *Chapter 4, subsection 202.11 of the 2005 Federal Food Code indicates,"...(A) Multiuse Food-Contact Surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..." 3. On 7/26/06 at 12:20 pm, during an observation of tray-line, a kitchen staff was observed to take the temperatures of each food item on the tray-line. The kitchen staff was observed to dip the stem of the thermometer into a sanitizing solution and did not sanitize the bottom of the head of the thermometer. The kitchen staff member was observed to push the thermometer into the tetrazzini so that the bottom of the head of the thermometer was in direct contact with the food. *Chapter 3, subsection 701.11 of the 2005 Federal Food Code indicates,"...(D) Food that is contaminated by food employees, consumers, or others though contact with their hands, bodily discharges, such as nasal or oral discharges, or other means shall be discarded." 4. On 7/26/06 at 11:05 am, in the kitchen dishroom, a fan was observed on the wall facing the dirty dishes and was covered in dust. The dietary manager acknowledged that the fan was dirty and needed to be cleaned. She indicated that maintenance was responsible for cleaning it and was not sure how often it got cleaned.	F 371		

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F 371	Continued From page 82 *Chapter 4, subsection 601.11 of the 2005 Federal Food Code indicates,"...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 5. On 7/26/06 at 11:05 am, in the kitchen, a large clean mixing bowl was observed to be stored upright and uncovered on the large mixer. The dietary manager and the cook was not sure when the bowl had been last used. The dietary manager indicated that she was not aware that the bowl should have been stored covered or inverted. *Chapter 4, subsection 903.11 of the 2005 Federal Food Code indicates,"...(B) Clean Equipment and Utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted..."	F 371		
F 372 SS=D	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained with the large garbage dumpsters. This was true for 1 of 3 large dumpsters. Findings include:	F 372	**Corrective Action:** Dietary manager exchanged the garbage dumpster with the broken lid to be used for cardboard and marked it as cardboard only to a covered intact lid for kitchen refuse. **Identification:** All residents are identified as potentially being affected. Continued on p. 84	

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F 372	Continued From page 83 On 7/24/06 at 8:35 am, during an observation on the dry storage area of the kitchen, a large dumpster was observed outside the back door of the kitchen full of garbage without a lid over the garbage. The dietary manager indicated that the garbage was picked up twice a week and that they were currently on a waiting list for a dumpster that had a lid. She also indicated the large dumpster that held the cardboard waste had a lid and that they should just switch out the large dumpsters so that the one currently holding the kitchen trash would have a lid.	F 372	**Systemic Changes:** All staff was inserviced by dietary supervisor and maintenance regarding placement of refuse and cardboard in the appropriate garbage dumpsters and to keep the kitchen refuse covered as required. (Please note that the facility continues to be on a long waiting list for new garbage dumpster containers) **Monitor:** Dietary supervisor and maintenance will monitor weekly that lids on garbage dumpsters are closed.	9/2/2006
F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure that in 1 of 1 locked medication room, multidose vials were dated after opening or were discarded when outdated. This had the potential to affected any residents who received medication from the multidose vials. The findings include: On 7/25/06 at 11:40 am, three 0.1 milliliter (ml) multidose vial of Tuberculin was observed in the	F 431	**Corrective Action:** All vials in the locked medication room refrigerator have been dated as opened on the date the vial was dispensed from the pharmacy. If no other date available and/or if greater than 28 days from dispensing date, the vials were discarded per facility pharmacy protocol. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** All staff will be inserviced on the appropriate dating of medication vials when opened as well as storage and discard date protocols. Continued on p. 85	

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F 431	Continued From page 84 refrigerator, on a shelf, in the locked medication room. All 3 had been opened and not dated. Four 5 ml multidose vial of Influenza virus vaccine dated as expired on June 20, 2006 were observed in the refrigerator, on a shelf, in the locked medication room. A LN was asked if she knew when the Tuberculin had been opened, she stated, "I don't know." She also indicated that the Tuberculin should have been dated once they were opened.	F 431	**Monitoring:** **1.** Pharmacy Nursing Consultant to continue to monitor medication room for appropriate drug storage, labeling, dating and discarding per protocol for compliance. **2.** DNS to audit the locked medication room weekly for appropriate drug storage, labeling, dating and discarding of medications per protocol to assure compliance and at Quality Assurance Committee Review.	9/2/2006
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and review of facility and resident records it was determined the facility failed to provide an infection control program that would ensure data collected, related to incidence of infection, was analyzed. Infections were not investigated as to their potential cause and infections were not controlled and prevented	F 441	**Corrective Action:** **1.** Resident's #4 and 5 were given the pneumovaccine. **2.** The facility infection control reports and logs continue to be utilized in the infection control review process. An additional form will be used to identify trends, clusters, and causative factors and preventative action plans including staff inservicing. **Identification:** All residents are identified as potentially being affected. Continued on p. 86	

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F 441	Continued From page 85 from spreading to other residents of the facility by monitoring staff practices. This had the potential to affect 100% of residents of the facility. Also, it was determined the facility did not ensure each resident was offered the pneumococcal vaccination. This was true for 2 of 11 sampled residents (#'s 4 & 5). The findings include: 1. The facility's Resident Infection Logs from January - July 2006 were reviewed. The results were as follows: January 2006 - UTI [urinary tract infections] - 4, URI [upper respiratory tract infections] 3, eye -1, skin -1, GI [gastrointestinal] -1, C-difficile. February 2006, UTI - 5, URI -3, LRI [lower respiratory tract infections] - 4, eye -1, skin -3, other -8 [4 admitted with]. March 2006 UTI -5, URI -1, LRI-3, eye-1, skin -1, other- 3. April 2006 UTI -5, URI- 1, LRI -1, skin -2, other- 2. May 2006 UTI-9, [admitted with - 2], LRI- 7 [admitted with - 4], Skin- 2 [MRSA]. C- difficile -1. June 2006, UTI -12, LRI -3, Skin - 7, c-difficile - 1 [discharged on 6/20/06]. A total of 23 infections with 10 residents admitted with infections. July 2006. UTI - 10 (3 infections were identified as ongoing), LRI -1, Skin -2 , other- 1. There had been a significant increase in infections in the month of May, June and July 2006 from earlier months.	F 441	**Systemic Changes:** **1.** DNS will be inserviced by Corporate Nurse Consultant on all Quality Assurance forms and process to be utilized in relationship to infection control as an adjunct to facility's current infection control program. **2.** Admission Checklist will be reviewed by DNS to assure compliance with the pneumovaccine administration. **3.** The facility's Medical Director will review all infections weekly as an adjunct to the facility's infection control program for further preventative consideration. **Monitor:** Administrator to monitor Quality Assurance process for facility infection control program compliance weekly and with the Quality Assurance Committee	9/2/2006

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F 441	Continued From page 86 The Resident Infection - Monthly reports were reviewed for January thought May 2006. June and July reports for 2006 were not available. The two infection reports/logs contained different information and there was no documented evidence the information was used in making decisions related to infection control. The DON was interviewed on 7/28/06 at 2:30 pm. She provided the infection control inservices, reports and minutes. She stated staff had been working to reduce the infections. The infection control minutes, dated June 2006, for April, May and June 2006 documented the following: April 2006 the facility had 5 UTI's, 2 residents admitted with the infection and 3 facility acquired. May 2006, the facility had 5 UTI's, 2 residents admitted with the infection and 2 facility acquired. June 2006, 9 UTI's, 2 admitted with the infection and 7 facility acquired, a 10 % increase in infections from the prior month. The monthly log/report indicated there were twelve UTI's. The infection control meeting minutes minutes reflected that leg bags were to be placed on all residents, when up, that have indwelling catheters to reduce the amount of "cross transmission." There was scientific rational for this change related to infection control. The two forms being used to collect data did not provide enough information to identify trends or possible clusters of infections. here was no system to consistently monitor staff practices and	F 441		

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provide education to change practices. Refer to F315 and F444 for specific examples related to infection control.

There were two inservices related to infection control conducted since January 2006. Inservice related to infection control was conducted on 2/27/06 with 12 staff attending and an inservice 7/21/06 with 5 staff attending.

A published article in 2001 by Strausbaugh LJ, "Epidemiology and prevention of infections in long term care facilities," documented 1.5-1.8 million residents of nursing homes in the United States have special risk factors including chronic disease, medications, malnutrition and functional impairments. The article documented, "Three types of endemic infections occur regularly in all these facilities: urinary tract infections, lower respiratory tract infections - principally pneumonia, and various skin and soft tissue infections." The article indicated that in one study an educational program stressing handwashing and the use of a portable virucidal foam decreased the infection rate 50 % and confirmed that traditional approaches to prevention of infections still applies.

2. Resident #4 was admitted to the facility on 7/29/04 with the diagnoses of Multiple Sclerosis, dementia, neuropathy, restless leg syndrome, chronic pain, and urinary retention.

Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain.

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F 441	Continued From page 88 On 7/25/06 at 12:50 pm, the DON and facility administrator were asked to provide the documentation that residents #4 and 5 were offered the pneumococcal vaccination. The DNS indicated she would look into the matter. On 7/26/06 at 9:05 am, the DON indicated resident #4 and 5 had not received the pneumococcal vaccination. The DON also indicated that these resident would receive them this week. The DON provided physician telephone order forms for both resident's documenting consent to give the vaccination. Resident #4's physician telephone order form, dated 7/25/06 documented, "May give pneumovac {sic}." A "Resident Vaccine Record" dated 7/26/06, documented that resident #4 received the pneumococcal vaccination on 7/26/06. Resident #5's physician telephone order form, dated 7/25/06 documented, "May give pneumovac {sic}." A "Resident Vaccine Record" dated 7/26/06, documented that resident #5 received the pneumococcal vaccination on 7/26/06.	F 441		

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F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure staff practiced appropriate handwashing and glove use before and after direct resident care. This affected 3 of 11 sample residents (#1, 8 and 10) and 2 random residents (#21 and 28). Findings include: The CDC Guidelines for Handwashing and Hospital Environmental Control 1985, documented the following: "a. Handwashing is the single most important procedure for preventing nosocomial infections. b. The indications for handwashing probably depend on the type, intensity, duration, and sequence of activity. c...handwashing is indicated, even when gloves are used after situations during which microbial contamination of the hands is likely to occur, especially those involving contact with...body fluids and after touching inanimate sources that are likely to be contaminated... d...handwashing should be encouraged when personnel are in doubt about the necessity for doing so." 1. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia,	F 444	**Corrective Action:** All staff have been inserviced on the regulation regarding hand washing with all care and services. Licensed staff have been inserviced on hand washing and wound care infection control protocols for residents receiving wound care changes, wound cleansing, medication administration and the differences between sterile and aseptic techniques (Sterile dressing changes are physician directed). This corrects the practice effecting residents #1,8,10, and 28. Resident #21 has been discharged. **Identification:** All residents are potentially affected **Systemic changes:** **1.** RCMs will monitor licensed nursing staff on medication pass, licensed nurse treatment techniques weekly to maintain compliance. **2.** DNS to inservice on infection control process and hand washing on new employee orientation and at licensed nurse and certified nursing assistant monthly meetings to assure appropriate education is in place for the facility infection control processes and to ensure compliance. **Monitor:** **1.** DNS will audit Resident Care Managers follow up with licensed nurse monitoring to assure training is complete and appropriate infection control practices are maintained. **2.** Administrator to monitor orientation programs monthly to assure all areas of infection control have been covered with all new employees. Administrator will review at Quality Assurance Committee meeting.	9/2/2006

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F 444	Continued From page 90 cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The resident was currently being treated for a MRSA infection to a stage IV pressure ulcer on the left ischial tuberosity and had a stage II pressure ulcer on the right ischial tuberosity. The resident was observed during a dressing change on 7/25/06 at 11:10 am. The LN removed the old dressing from the wound on the resident's right ischial tuberosity first. After removing the contaminated dressing, the LN was not observed to change her gloves before cleansing the wound and applying a clean dressing. After completing the care for the first wound, the LN removed the old dressing on the resident's wound on the left ischial tuberosity. The LN was not observed to change her gloves or to wash or sanitize her hands in between wounds. After removing the contaminated dressing, the LN was not observed to change her gloves or to wash or sanitize her hands before cleansing the stage IV wound. After cleansing the wound, the LN reached into her pocket with her contaminated gloves and got out a pair of scissors to cut the new dressing. After cutting the new dressing to size, the LN was observed to put the contaminated scissors back into her pocket with her gloved hand. After applying the clean dressing, the LN was observed to reach into her pocket and pull out a Sharpie marking pen with her contaminated gloves. After writing on the new dressing, the LN was observed to place the contaminated Sharpie pen back into her pocket. Throughout this procedure, the LN was not observed to remove her contaminated or to wash or sanitize her hands.	F 444		

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F 444	Continued From page 91 After completing the wound dressing changes, the LN proceeded to assist the CNA in repositioning the resident. The resident had a bowel movement and required clean up and peri care. The LN got herself and the CNA a clean pair of gloves from a box on the wall. The LN was not observed to wash or sanitize her hands before handling the clean gloves or after removing her contaminated gloves. A LN demonstrated poor infection control practices during an observation of wound dressing changes on a resident being treated for MRSA. The LN's poor infection control practices created the potential for cross-contamination and increased the risk of passing on infections to other residents in the facility. 2. Resident #10 was admitted to the facility on 6/24/06 with the diagnoses of CVA [stroke] and dementia. The admission MDS assessment, dated 7/5/06, indicated the resident was severely impaired cognitively and required total assistance of one/or two person for all ADL's including hygiene. "Skin Condition Progress Notes," dated 7/11/06, indicated the resident had "many tiny red open areas on the right buttocks." On 7/28/06 at 9:25 am, the resident was observed during a dressing change to the wound. The LN removed clean dressings from the cart and took them to the resident's bedside. She placed the dressings on the overbed table without wiping the table or using a clean barrier. The LN gloved and assisted the CNA to remove feces	F 444		

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from the resident's buttocks, removed the soiled dressing, picked up a container of Laniseptic from the table to read the label, cleansed the wound and applied a clean dressing without changing the contaminated gloves.

Failure to follow aseptic technique with wound care placed the resident at risk for infection. This increased the risk of infection for other residents by staff moving from room to room and handling contaminated tables and supplies.

3. Resident #8 was originally admitted to the facility on 1/26/1995, and readmitted on 3/25/04, with diagnoses including paraplegia, schizophrenia, neurogenic bladder, UTI (urinary tract infection), status post venous thrombosis and cellulitis of the buttocks.

The most recent quarterly assessment, dated 5/26/06, documented the resident was severely impaired cognition, was totally dependent for all care and had a suprapubic catheter in place.

An Interdisciplinary Progress Note dated 5/4/06 documented, "... the resident has acquired two small stage II ulcers to the gluteal fold."

On 7/28/06 at 11:00 am, the surveyor observed a LN change the dressing to the resident's pressure sore. The LN obtained the clean dressings from a cart, placed the clean supplies on the resident's bedside table without cleaning the table or providing a barrier between the clean supplies and the contaminated over bed table. The LN gloved, removed the dressing, cleansed the wound and placed the contaminated dressings on the overbed table. Then using the hand with the

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F 444	Continued From page 93 contaminated glove adjusted the lighting with the light switch and replaced the clean dressing. The facility's wound care policy was reviewed. The following areas in the facilitys policy/procedure regarding dressing changes were not followed. a) Use disposable cloth [paper towel is adequate] to establish a clean field. b) Place all the items to be used during the procedure on the clean field. c) Place disposable cloth under the wound to serve as a protection for the bed linen and other body sites. d) Put on exam glove and remove dressing. e) Pull the glove over the dressing and discard in appropriate receptacle. Wash hands. f) Put on disposable gloves. g) Place one gauze over the broken skin, that is usually covered by the dressing, wash tissue around the wound. h) Remove dry gauze and apply treatment. Failure to follow aseptic technique during dressing changes placed residents at risk for infection. 4. An LN was observed on 7/25/06 at 12:38 pm during a medication pass. The LN was observed administering one eye drop into both of random resident #28's eyes. The LN was not observed to wash or sanitize her hands before or after administering the eye drops. The LN was not observed to wash or sanitize her hands immediately after leaving the resident's room. 5. During a medication pass observation on	F 444		

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F 444	Continued From page 94 7/25/06 at 6:45 am, a LN was observed to handle a resident's medication with her ungloved hand. The LN was preparing medications for random resident #21. She stated the resident liked the B-1 tablet cut in half and was observed picking up the medication with her ungloved hand and placing it in the pill splitter. The LN was not observed to wash or sanitize her hands before preparing this resident's medications. An LN touched a resident's medication with her ungloved hand potentially exposing the resident to infection. This is a repeat violation from the annual survey of 7/15/05.	F 444		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure that all portions of the call system were in working order. A call light did not illuminate outside of 1 of 2 shower rooms on the 200 hall. This had the potential to affect all residents who used this shower room. Findings include: During the environmental inspection on 7/26/06 at	F 463	**Corrective Action:** The call light on the outside of the 200 hall shower room was repaired during the survey. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** Maintenance supervisor to complete environmental rounds weekly to identify areas that are in need of repair and complete the repair **Monitor:** Maintenance supervisor and Administrator to audit environmental rounds weekly for compliance and to assure all needed repairs were completed. Audits will be reviewed at the Quality Assurance Committee meetings.	9/2/2006

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F 463	Continued From page 95 3:33 pm, the call light in the 2nd shower room from the nurses' station in the 200 hall was tested. The light outside the shower room door was found to be not working. The maintenance man stepped out into the hallway to assess the situation and said, "Well, there's no bulb in it...that's why it's not working..." He indicated he would replace the bulb immediately following the environmental inspection. The surveyor tested the call light in the shower room on the evening of 7/26/06 and the call light was found to be in working order.	F 463		
F 490 SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, it was determined the facility was not administered in a manner that enabled it to use its resources effectively and efficiently toward the betterment of each resident. 1) The facility failed to develop policy and procedures specific to emergency power outage and failed to demonstrate knowledge on emergency power outage procedures. This failed practice had the potential for harm constituting immediate jeopardy to residents' health and	F 490	**Corrective Action:** **1.** Regarding #1, the facility provided a plan of correction during the survey on 7/26/06 that was accepted at the time with further request for additional plan of correction that was provided to Idaho Health and Welfare on 8/15/06. See attached copy of addendum to the plan of correction. **2.** Regarding # 2, See plan of correction for F-315 that was accepted on 7/28/06 by Idaho Health and Welfare. See attached copy of plan of correction. Continued on p. 97	

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F 490	Continued From page 96 safety. 2)The facility failed to identify risks and assess residents at risk for urinary tract infection and to develop and implement care plans and interventions in a timely manner related to urinary tract infections and catheter care. This failed practice resulted in serious harm to residents' health and safety. This affected 4 of 11 sample residents (#'s 1, 2, 3 and 8). Resident #2 was hospitalized in December of 2005 with pyelonephritis that required stent placement and in February 2006 with a urinary tract infection. Resident #1 was hospitalized in May of 2006 with a urinary tract infection. The facility did not assess, care plan or implement a procudure to establish resident #3's continence after removal of a foley catheter. This resulted in the resident being total incontinent. Resident #8 had a supra pubic catheter in place and was at risk for UTIs. The facility did not assess resident #8 at high risk for UTI and had no documented preventative measures in place. Resident #8 was being treated for a urinary tract infection during the survey. 3) At the time of the survey, the DON was acting as the social services designee in the absence of a social worker. The DON was also responsible for staff development in the facility and for RN oversight of MDS assessments. Due to the lack of DON supervision, the facility did not ensure RN coverage for 4 of 21 days reviewed on a three-week staffing schedule. 4) The facility failed to provide an infection control program that would ensure data collected, related to incidence of infection, was analyzed. Infections	F 490	**3.** With regard to #3, to reduce the DNS responsibility load and increase nursing system oversight the following has been done: a. The Resident Care Managers will have their duties redistributed to include Minimum Data Set (MDS) completion. b. The facility is actively in the hiring process of a Social Service Director and final interview processes are in place. Corporate Social Service Consultant will Provide site visits weekly to augment this role until the New Social Service Director can be hired and trained. c. All of the department managers currently participate in the staff development of each of their assigned department staff and assist in the orientation of all new facility employees and will continue to do so. d. See F-354 regarding staff coordinator's and DNS' responsibilities in relationship to compliance with 8 hour RN coverage. **4.** See F-441 and F-444 for Plan of Correction related to review and improvements in facility infection control process. **5.** F-225 for plan of correction in relationship to inservicing staff on correct and complete accident and incident report process including pressure ulcer identification, cause and preventative intervention. **Identification:** All residents are identified as potentially being affected. Continued on p. 98	

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F 490	Continued From page 97 were not investigated as to their potential cause and infections were not controlled and prevented from spreading to other residents of the facility by monitoring staff practices. 5) The facility did not ensure that injuries of unknown origin were thoroughly investigated to rule out the possibility of abuse. Findings include: 1. The facility failed to develop policy and procedures specific to emergency power outage and failed to demonstrate knowledge on emergency power outage procedures. This failed practice had the potential for harm constituting immediate jeopardy to residents' health and safety. Please refer to F518 for further details regarding this immediate jeopardy situation. 2. Urinary Tract Infections and Bladder Assessments a. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted on 2/25/06 with diagnoses including Multiple Sclerosis, urinary retention, and history of urinary tract infections (UTI) and pyelonephritis with stent placement. On 6/6/06, the resident had a suprapubic catheter placed. Prior to that the resident had a Foley catheter in place due to the urinary retention. The resident's care plan did not address the prevention of urinary tract infections or catheter care.	F 490	**Systemic Changes:** **1.** The DNS with the assistance of the Corporate Nurse Consultant will review the Resident Care Manager's job descriptions and inservice in the areas of the RCM roles to reduce the RCM coverage currently being completed by the DNS. **2.** The Corporate Nurse Consultant will assure 20 hours per week of support and education to assure training needs are met and facility is in compliance. **3.** Refer to F- 225, F-250, F-315, F-354, F-441, and F-444 for further systemic corrections in relationship to this area. **Monitor:** Monitoring of all areas to take place by DNS, Administrator and Corporate Nurse Consultant weekly and with Quality Assurance Committee to assure compliance.	9/2/2006

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F 490	Continued From page 98 The resident was hospitalized from 12/14 to 12/20/05 for pyelonephritis that required stent placement. The resident was again hospitalized on 2/22/06 for a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. b. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The resident had a suprapubic catheter due to a neurogenic bladder. Prior to the resident's original admission, he had been in a local hospital and was being treated for urosepsis. The resident was admitted to the hospital on 5/17/06 for a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. Please refer to F315 for further details including information regard residents #3 and #8. 3. The facility did not ensure that a registered nurse (RN) worked 8 hours each day for 4 of 21 days reviewed (7/2/06, 7/3/06, 7/9/06, and 7/16/06). Also, the facility did not ensure the DON devoted full time to supervising and managing the nursing department.	F 490		

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F 490	Continued From page 99 At the time of the survey, the DON was acting as the social services designee in the absence of a social worker. The DON was also responsible for staff development in the facility and for RN oversight of MDS assessments. Please refer to F250 for further details related to social services. Please refer to F354 for further details related to RN coverage. 4. The facility failed to provide an infection control program that would ensure data collected, related to incidence of infection, was analyzed. Infections were not investigated as to their potential cause and infections were not controlled and prevented from spreading to other residents of the facility by monitoring staff practices. Please refer to F441 and F444 for further details. 5. The facility did not ensure that injuries of unknown origin were thoroughly investigated to rule out abuse. Please refer to F225 for further details.	F 490		

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F 492 SS=B	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure that staffing numbers were posted on 7/24 and 7/25/06. This had the potential to affect all residents residing in the facilty. Findings include: On 7/24/06 at 12:33 pm, the surveyor located the staffing numbers board. It was located across from the nurses' station near the water fountain and the clean utility room. The caption on the top of the board was "Today's Direct Care Staff" and directly underneath listed the job titles "RN", "LPN", and "CNA." There were no numbers following any of the job titles. The board was again observed at 3:00 pm and appeared as described above. On 7/24/06 at 3:36 pm, the board read "RN [left blank]", "LPN 2" and "CNA 4." According to documentation on the board there was also one CNA in training. The board was not dated and the shift was not identified. On 7/25/06 at 9:00 am, the board contained the exact information as 7/24/06 at 3:36 pm. The information on the board remained the same	F 492	**Corrective Action:** The Staffing Coordinator will assure all shifts have staff assigned, date and shift worked posted daily. Licensed staff will make any corrections to the daily posted schedule each shift as applicable. **Identification:** All residents are identified as potentially being affected **Systemic Changes:** Staffing Coordinator and licensed nurse staff will be inserviced on the completion of the daily assignment postings and their responsibilities to complete and/or make corrections as applicable to each shift posting. **Monitoring:** Administrator will audit weekly for posting compliance	9/2/2006

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F 492	Continued From page 101 on 7/25/06 at 10:30 am and 1:30 pm. The facility was informed about the lack of accurate information on the board on 7/25/06 at 3:25 pm. On 7/26/06 at 6:11 am, the information on the board was unchanged from the observation on 7/24/06 at 3:36 pm. On 7/26/06 at 8:00 am, the board read "LPN 2" and "CNA 5" with no numbers posted for RNs. The board was not dated and the shift was not identified. On 7/26/06 at 4:03 pm, the board read "RN 1", "LPN 2" and CNA 5. The board documented one RN as in-training. The board was not dated and the shift was not identified. Due to the lack of complete and accurate information on the staffing numbers board, it was difficult for residents and family members to ascertain exactly how many staff were working the floor each shift. Not dating the board or identify a specific shift further confused the issue.	F 492		

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F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined that the facility did not ensure clinical records for 6 of 11 sampled residents (#'s 1, 2, 3, 4, 5 & 6) were complete and accurately documented. Findings include: 1. Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain. On 7/25/06 at 8:55 am, resident #5 was observed in the Sun Lounge dining room eating his breakfast. Once the resident was finished a NA asked the resident if he was finished eating and the resident did not respond back. The NA took the resident's tray. The surveyor several minutes later asked the NA for the meal monitor sheets to see what was recorded. The July meal monitor sheet recorded 10% and an R (refused) was recorded under replacement and house supplement. The NA was asked if he offered	F 514	**Corrective Action:** **1.** Resident #5, see F-309 plan of correction regarding inservice and documentation accuracy of meal monitors to the certified nursing assistant staff. **2.** Resident #4, see F-279 plan of correction regarding inservicing of the interdisciplinary team members on accurate care plan completion to include dating and initialing changes and updates to the resident's care plan. **3.** Resident #1, see F-309 plan of correction in regards to inservice and documentation of meal monitors, meal consumption, fluid consumption and meal replacement. **4.** Residents # 2, 3, and 6 cannot have documentation corrected for previous missed activity of daily living (ADL) documentation. See F-309 plan of correction in regards to documentation of meal monitors for accuracy. **5.** All certified nursing assistant staff will be inserviced on activities of daily living (ADL) documentation including refusal of showers, reporting refusal of showers to licensed nursing staff and to reschedule or offer alternative to a shower, for example a bed bath unless contraindicated. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** See F-309 for meal monitoring reviews and audits by Dietary Supervisor and DNS weekly. **2.** Activity of daily living flow sheets will be audited weekly by the Administrator and Staffing Coordinator to assure compliance with documentation requirements. Continued on p. 104	

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F 514	Continued From page 103 these items to the resident. The NA indicated that he just had. The survey was next to the resident this entire time and the NA did not offer this items to the resident. When the NA was made aware of this, the NA indicated that he did not offer them and that he thought that another NA had and thought that the resident had refused that was why he had recorded the refusal. At this time the DNS was made aware of this. The DNS provided the surveyor with a copy of the meal monitor sheet and indicated that the resident should have been offered an alternate and a supplement. The surveyor recorded that the resident ate 30% of this meal. The NA not only documented that the resident refused the alternative and supplement but also recorded the percent of meal eaten incorrectly. 2. Resident #4 was admitted to the facility on 7/29/04 with the diagnoses of Multiple Sclerosis, dementia, neuropathy, restless leg syndrome, chronic pain, and urinary retention. Resident #4's most recent care plan, did not have a date on it when the care plan was initiated. 3. Resident #1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, neurogenic bladder, chronic anemia, and chronic leukopenia. The meal monitor, dated 6/06, was not complete.	F 514	**Monitor:** **1.** See F-309 for monitoring process by DNS and Dietary Supervisor regarding meal monitor completion. **2.** Administrator and Staffing coordinator to audit activity of daily living (ADL) flow sheets weekly to ensure compliance and notify DNS for inservice follow up as applicable and review at Quality Assurance Committee meeting.	9/2/2006

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F 514	Continued From page 104 The resident's meal and fluid consumption was not documented on 6/28 (breakfast), 6/19 (lunch) and 6/23 (dinner). The facility did not document if a replacement was offered when the resident ate 50% or less of his meal on the following dates: Lunch: June 3rd and 5th Dinner: June 15th and 24th. The meal monitor, dated 7/06, was not complete. The resident's meal and fluid consumption was not documented on 7/23 (breakfast) and 7/24 (lunch). The facility did not document if a replacement was offered when the resident ate 50% or less of his meal on July 7, 8, 9 and 15 (dinner). 4. Resident #6 was admitted to the facility on 7/31/00 with diagnoses including pancreatitis, congestive heart failure, wrist injuiry, hypertension, osteoporosis, coronary artery disease and non-union fractures of C1 and C2 (cervical spine vertebrae). The "CNA Flow Sheet..." was reviewed for 7/06. According to the flow sheet, the resident was to receive a shower twice a week on Tuesdays and Fridays. There was no documentation to indicate the resident was bathed or refused to bathe on 7/14/ and 7/18. The meal monitor for 6/06 was not complete. The resident's meal and fluid consumption was not documented on 6/28 (breakfast), 6/17 (dinner) and 6/18 and 6/23 (dinner). The facility did not documente if a replacement was offered when the resident ate 50% or less of her meal on June 4, 7, 9, 10 and 27 (breakfast) and June 15, 19, 27 and 28 (dinner). The meal monitor for 7/06 was not complete. The	F 514		

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F 514	Continued From page 105 resident's meal and fluid consumption was not documented on July 14. The facility did not document if a replacement was offered when the resident ate 50% or less of her meal on June 17. The snack monitor for 7/06 was not complete. The facility did not document if the resident accepted or refused a bedtime snack on July 2, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, and 23. 5. Similar findings for residents #2 and #3 related to meal monitoring and CNA flow sheets.	F 514		
F 518 SS=K	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to develop policy and procedures specific to emergency power outage and failed to demonstrate knowledge on emergency power outage procedures. This failed practice had the potential for harm constituting immediate jeopardy to residents' health and safety. At the time of the survey, the facility had at least 7 residents dependent on oxygen (sample resident #7 & random residents #'s 19, 22, 24, 25, 26 and 27), 1 resident who required suctioning and was tube fed (#7), and at least 8 residents on	F 518	**Corrective Action:** Plan of correction for F-518 was submitted and accepted by Idaho Health and Welfare on 7/24/06. Request for further additions to the plan of correction was made by Idaho Health and Safety and this was completed and submitted on 8/15/06. Please see attached copy of the Plan of correction and the addendum Plan of correction.	9/15/2006

Marquis Care at Shaw Mountain
Plan of Correction for F518 J
Addendum
August 25, 2006

As reviewed with the Department of Health and Welfare Long Term Care Supervisor, Loretta Todd on 8/21/2006, the interim generator will remain in effect until the permanent generator can be on site and installed. Based on estimates for generator delivery and construction schedules, we are fairly certain the September 15, 2006 completion date for this project is still viable. If a revision to this date is needed, Loretta Todd will be notified via phone and in writing as to the necessary revisions.

Marquis Care at Shaw Mountain
Plan of Correction for F518 J
Addendum
August 14, 2006

Corrective Action:

Phase One:

A temporary generator will be placed on site and hooked into the existing automatic transfer box and wiring. This generator will be supplied by EC Power Systems in Boise, ID. The installation will be completed by Mountain Power Electrical Co., a licensed electrical contractor in Boise, ID. The temporary unit is diesel-powered and will provide 12kw of power to the facility in the event of a power outage. **This project will be completed on Wednesday, August 16, 2006.**

Staff will continue to follow the current policy and procedure regarding a power outage. In addition to the current procedure, the facility has 8 "K" oxygen tanks on site that are available for emergency use by residents on oxygen, if the need arises. There are six regulators available for use with the "K" tanks. A battery-powered suction machine has been purchased and is available for use if needed also. Staff will be inserviced on the use of the "K" tanks and the suction machine. This inservice will be completed by August 16, 2006.

Phase Two:

A permanent generator will be installed on site. The new generator will be a diesel-powered 30kw capacity unit manufactured by Kohler. (See attached specification sheet) This unit will be supplied by EC Power Systems and be installed by Mountain Power Electrical Co. This generator will supply emergency power to all existing areas powered by the current generator during a power outage situation. This project will also include wiring and installation of three (3) additional emergency power outlets throughout the facility. Specifically, outlets would be added to 100 Hall, 200 Hall, and Friendship House (locked unit) respectively. **This project will be completed by September 15, 2006.**

All staff will be inserviced regarding policy and procedure changes related to the new generator and aforementioned emergency plugs outlets

Identification:

All residents are identified as potentially being affected by this deficient practice.

Systemic Changes:

Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance to ensure compliance.

Monitor: Administrator and/or Maintenance Supervisor to audit staff knowledge of emergency power outage policy and procedure on a monthly basis for three months and then quarterly thereafter. QA Committee to review quarterly to ensure compliance.

Completion Date: September 16, 2006

Marquis Care at Shaw Mountain
Plan of Correction for F518 J
July 26, 2006

Corrective Action:

All staff to be inserviced on emergency power outage policy and procedures in order to maintain life safety in the facility in the event of a power outage.

Completion Date: 8/4/2006
Person Responsible: Joe Rudd, Administrator

Identification:

All residents are identified as potentially being affected by this deficient practice.

Systemic Changes:

Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance Supervisor to ensure compliance.

Monitor:

Administrator and/or Maintenance Supervisor to audit staff knowledge of this policy and procedure weekly for four weeks and the quarterly thereafter. QA Committee to review quarterly to ensure compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. BUILDING _____ B. WING _____	08/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 106 airbeds (sample residents #'s 1, 2, 4, 7, 8, and 9 and random residents # 's 22 and 23) . This failed practice was brought to the attention of the facility's administration on 7/26/06 at 7:47 pm and the facility was provided specific details of the failure to develop and implement policy and procedures on emergency power outage. The facility was instructed to begin immediate removal of the risk to individuals and immediately implement corrective measures to prevent repeat jeopardy situations. On 7/26/06 at 8:08 pm, the Administrator stated all staff on the shift would be in-serviced immediately and a walk through would be conducted with management staff. He stated 100% of staff that was coming on for the night and the next day shift would be in-serviced regarding the emergency power outage procedures. At that time, the immediate jeopardy was abated. On 7/27/06 at 7:37 am, the Administrator provided the surveyors with an acceptable plan of correction. The plan of correction was as follows: "All staff to be inserviced on emergency power outage policy and procedures in order to maintain life safety in the facility in the event of a power outage. Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance Supervisor to ensure compliance.	F 518		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 107 Administrator and/or Maintenance Supervisor to audit staff knowledge of this policy and procedure weekly for four weeks and quarterly thereafter. QA [Quality Assurance] Committee to review quarterly to ensure compliance." Findings include: During the environmental inspection with the Maintenance Supervisor on 7/26/06 at 3:16 pm, the surveyor noted the facility had one red emergency outlet to access power from the generator in the event of a power outage. The red outlet was located in an area where offices were located, between the nursing facility and the new Alzheimer's wing, and was not visible from the nurses' station or any resident care areas in the facility. The maintenance man stated there were 2 locations to access extension cords and during a power outage, staff were to string extension cords from the red outlet down the various halls to residents' rooms. The maintenance man stated drills were held quarterly for each shift and education was also provided at new employee orientation regarding the location of the red outlet and access instructions. The facility was licensed for 97 beds. At 5:08 pm on 7/26/06, the DON was interviewed regarding emergency procedures during a power outage and the location of the red outlet. She stated she did not know and that she would call the maintenance man if the situation ever arose. She acknowledged she had no idea where the red emergency outlet was. At 5:11 pm on 7/26/06, the charge LN on the	F 518		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 518	Continued From page 108	F 518		

evening shift was interviewed regarding the location of the red outlet and emergency procedures in the event of a power outage. Initially she verbalized no understanding of how the system worked, indicating she assumed the generator power automatically "kicked on" when there was a power outage. She eventually stated she would "find a red plug." She stated the red outlet was in the clean utility room near the nurses' station. A surveyor accompanied the LN into the clean utility room. No red outlet was found.

From 5:08 pm to 6:54 pm, a total of 9 staff were interviewed regarding emergency procedures during a power outage and the location of the red plug-in. Two employees, a housekeeper and a Resident Care Manager, who normally worked the day shift knew the location of the red outlet and where the extension cords were located. The rest of the staff, which included LNs and CNAs, did not. One LN stated she had seen "...red outlets in the hallway..." but could not specify where. She stated, "...you'd just plug things like O2 [oxygen] concentrators in..."

On 7/26/06 at 6:03 pm, the maintenance man was unable to produce policy and procedures relating to emergency power outage when this information was requested by the surveyors. He indicated he would keep looking for them but at the time, couldn't find any. The maintenance man was not able produce policy and procedures specific to emergency power outage at any point in time before the immediate jeopardy was called. As part of their plan of correction, the facility created a policy and step-by-step written procedures.

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MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

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F 518	Continued From page 109 The Administrator was interviewed on 7/26/06 at 6:56 pm regarding the emergency outlet and staff's lack of knowledge about its location and the emergency procedure. He stated this was a topic that was covered in orientation along with fire safety and said, "...but apparently not enough...there's not much else I can say..." He left the room at the conclusion of the interview to check the new employee orientation packet to see how this issue was addressed. He said, "We're going to in-service staff tomorrow..." When the facility's administrative staff was informed of the immediate jeopardy situation on 7/26/06 at 7:47 pm, the administrator stated, "All staff on board now have been in-serviced." On 7/26/06 at 8:08 pm, the Administrator stated all staff on the shift would be in-serviced immediately and a walk through would be conducted with management staff. He stated 100% of staff that was coming on for the night and the next day shift would be in-serviced regarding the emergency power outage procedures. At the time of survey, there were 7+ residents (sample residents #'s 7 & and random residents #'s 19, 22, 24, 25, 26 and 27) who relied on oxygen, 8+ residents who were on air beds (sample residents #'s 1, 2, 4, 7, 8, and 9 and random residents # 's 22 and 23) and one sample resident (#7) with throat cancer who also required suctioning to maintain an airway and was tube fed. Four of the residents on airbeds had limited or no use of their extremities (sample residents #'s 1, 2, & 8 and random resident #23). These	F 518		

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MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

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F 518	Continued From page 110 residents risked suffocation if the beds were to deflate in the event of a power failure. The local area had undergone multiple days of at least 100 degree temperatures and because of forest fires threatening a power supply, the local power company was considering rolling blackouts. Due to the staff's lack of knowledge about procedures during an emergency power outage and the fact that the facility could not produce policy and procedures addressing this specific issue, it was determined that residents were at risk for serious harm, constituting immediate jeopardy.	F 518		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135090	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/2/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	**909 RESERVE ST BOISE, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, it was determined the facility did not ensure the accuracy of MDS assessments. This affected 2 of 11 sample residents (#'s 1 & 3). Resident #1's MDS inaccurately recorded side rails as restraints. Resident #3's MDS incorrectly coded the resident's vision. Findings include:

1. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, neurogenic bladder, chronic anemia, and chronic leukopenia. The resident was on an airbed for pressure relief to maintain skin integrity.

Section P4 "Devices And Restraints" of an MDS dated 3/24/06, was coded to indicate the resident had full side rails on all open sides of the bed and the side rails were used daily.

The MDS, dated 3/17/06, contained the same information in Section P4 as documented above.

The resident's most current MDS, dated 6/5/06, did not code the full side rails as restraints.

The side rails were used to maintain the integrity of the airbed, not to prevent the resident from getting out of bed. The side rails were not being utilized as a restraint and did not need to be coded as a restraint.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135090	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/2/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	**909 RESERVE ST BOISE, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 2. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke], hematoma of left leg, cataracts, glaucoma and dementia. An admission MDS, dated 5/9/06, documented the resident had no impairments in vision or visual limitations/difficulties in Section D. An "Assessment Summary" dated 5/11/06, documented the following: "Nutrition:...Resident eyesight is poor..." The resident was observed during a meal on 7/25/06 at 8:23 am. The CNA sat beside the resident and told her where the various food was positioned on her plate. The resident's MDS was incorrectly coded in relation to vision deficits/difficulties. Due to the incorrect coding, a RAP did not trigger and the resident's visual deficit was not care planned. A Resident Care Manager responsible for MDS coding was interviewed on 7/27/06 at 12:35 pm regarding the resident's vision and the accuracy of the coding. She acknowledged the resident did have visual deficits and stated, "...it's a mis-code..." The MDS is a comprehensive assessment tool which was designed to help a facility to develop an individualized care plan and enables the facility to track changes in resident status. The usefulness of this tool depends on the facility's ability to accurately code information.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lory Dayley, RD, Team Coordinator Lisa Kaiser, RN Betty Vivian, RN, MSN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	The following POC is being submitted as required by federal regulation. The submission of this POC is not to be construed in any way as an admission by the facility of the deficiency nor the finding of fact. RECEIVED AUG 25 2006 DIV. OF MEDICAID	
C 107	02.100,02,b b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service and of the operation of its physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious	C 107	Please refer to F 490	

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C 107	Continued From page 1 beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations of both parties. This Rule is not met as evidenced by: Please refer to F490 as it relates to the Administrator's failure to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently toward the betterment of each resident.	C 107		
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to the facility's failure to ensure a resident's dignity in regards to privacy.	C 125	Please refer to F 241	
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it relates to the facility's	C 175	Please refer to F 225	

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C 175	Continued From page 2 failure to thoroughly investigate injuries of unknown origin.	C 175		
C 239	02.106,04 EMERGENCY PLANS PROTECTION & EVACUATION 04. Emergency Plans for Protection and Evacuation of Patients/Residents. In cooperation with the local fire authority, the administrator shall develop a written plan for employee response for protection of patients/residents in case of an emergency. The plan shall include at least the following: This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to develop policy and procedures specific to emergency power outage and failed to demonstrate knowledge on emergency power outage procedures. This failed practice had the potential for harm constituting immediate jeopardy to residents' health and safety. At the time of the survey, the facility had at least 7 residents dependent on oxygen (sample resident #7 & random residents #'s 19, 22, 24, 25, 26 and 27), 1 resident who required suctioning and was tube fed (#7), and at least 8 residents on airbeds (sample residents #'s 1, 2, 4, 7, 8, and 9 and random residents # 's 22 and 23) . This failed practice was brought to the attention of the facility's administration on 7/26/06 at 7:47 pm and the facility was provided specific details of the failure to develop and implement policy and procedures on emergency power outage. The facility was instructed to begin immediate removal of the risk to individuals and immediately	C 239	Please refer to F 518	

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C 239	Continued From page 3 implement corrective measures to prevent repeat jeopardy situations. On 7/26/06 at 8:08 pm, the Administrator stated all staff on the shift would be in-serviced immediately and a walk through would be conducted with management staff. He stated 100% of staff that was coming on for the night and the next day shift would be in-serviced regarding the emergency power outage procedures. At that time, the immediate jeopardy was abated. On 7/27/06 at 7:37 am, the Administrator provided the surveyors with an acceptable plan of correction. The plan of correction was as follows: "All staff to be inserviced on emergency power outage policy and procedures in order to maintain life safety in the facility in the event of a power outage. Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance Supervisor to ensure compliance. Administrator and/or Maintenance Supervisor to audit staff knowledge of this policy and procedure weekly for four weeks and quarterly thereafter. QA [Quality Assurance] Committee to review quarterly to ensure compliance." Findings include: During the environmental inspection with the Maintenance Supervisor on 7/26/06 at 3:16 pm, the surveyor noted the facility had one red emergency outlet to access power from the	C 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 239	Continued From page 4 generator in the event of a power outage. The red outlet was located in an area where offices were located, between the nursing facility and the new Alzheimer's wing, and was not visible from the nurses' station or any resident care areas in the facility. The maintenance man stated there were 2 locations to access extension cords and during a power outage, staff were to string extension cords from the red outlet down the various halls to residents' rooms. The maintenance man stated drills were held quarterly for each shift and education was also provided at new employee orientation regarding the location of the red outlet and access instructions. The facility was licensed for 97 beds. At 5:08 pm on 7/26/06, the DON was interviewed regarding emergency procedures during a power outage and the location of the red outlet. She stated she did not know and that she would call the maintenance man if the situation ever arose. She acknowledged she had no idea where the red emergency outlet was. At 5:11 pm on 7/26/06, the charge LN on the evening shift was interviewed regarding the location of the red outlet and emergency procedures in the event of a power outage. Initially she verbalized no understanding of how the system worked, indicating she assumed the generator power automatically "kicked on" when there was a power outage. She eventually stated she would "find a red plug." She stated the red outlet was in the clean utility room near the nurses' station. A surveyor accompanied the LN into the clean utility room. No red outlet was found. From 5:08 pm to 6:54 pm, a total of 9 staff were interviewed regarding emergency procedures	C 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 239	Continued From page 5 during a power outage and the location of the red plug-in. Two employees, a housekeeper and a Resident Care Manager, who normally worked the day shift knew the location of the red outlet and where the extension cords were located. The rest of the staff, which included LNs and CNAs, did not. One LN stated she had seen "...red outlets in the hallway..." but could not specify where. She stated, "...you'd just plug things like O2 [oxygen] concentrators in..." On 7/26/06 at 6:03 pm, the maintenance man was unable to produce policy and procedures relating to emergency power outage when this information was requested by the surveyors. He indicated he would keep looking for them but at the time, couldn't find any. The maintenance man was not able produce policy and procedures specific to emergency power outage at any point in time before the immediate jeopardy was called. As part of their plan of correction, the facility created a policy and step-by-step written procedures. The Administrator was interviewed on 7/26/06 at 6:56 pm regarding the emergency outlet and staff's lack of knowledge about its location and the emergency procedure. He stated this was a topic that was covered in orientation along with fire safety and said, "...but apparently not enough...there's not much else I can say..." He left the room at the conclusion of the interview to check the new employee orientation packet to see how this issue was addressed. He said, "We're going to in-service staff tomorrow..." When the facility's administrative staff was informed of the immediate jeopardy situation on 7/26/06 at 7:47 pm, the administrator stated, "All staff on board now have been in-serviced."	C 239		

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C 239	Continued From page 6 On 7/26/06 at 8:08 pm, the Administrator stated all staff on the shift would be in-serviced immediately and a walk through would be conducted with management staff. He stated 100% of staff that was coming on for the night and the next day shift would be in-serviced regarding the emergency power outage procedures. At the time of survey, there were 7+ residents (sample residents #'s 7 & and random residents #'s 19, 22, 24, 25, 26 and 27) who relied on oxygen, 8+ residents who were on air beds (sample residents #'s 1, 2, 4, 7, 8, and 9 and random residents # 's 22 and 23) and one sample resident (#7) with throat cancer who also required suctioning to maintain an airway and was tube fed. Four of the residents on airbeds had limited or no use of their extremities (sample residents #'s 1, 2, & 8 and random resident #23). These residents risked suffocation if the beds were to deflate in the event of a power failure. The local area had undergone multiple days of at least 100 degree temperatures and because of forest fires threatening a power supply, the local power company was considering rolling blackouts. Due to the staff's lack of knowledge about procedures during an emergency power outage and the fact that the facility could not produce policy and procedures addressing this specific issue, it was determined that residents were at risk for serious harm, constituting immediate jeopardy.	C 239		
C 293	02.107,04,b b. Therapeutic diets shall be planned in accordance with the physician's order. To the extent that it is medically possible, it shall be	C 293	Please refer to F 367	

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C 293	Continued From page 7 planned from the regular menu and shall meet the patient's/resident's daily need for nutrients. This Rule is not met as evidenced by: Please refer to F367 as it relates to the facility's failure to ensure residents were provided with diets as prescribed by their physician.	C 293		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it relates to the facility's failure to ensure sanitary conditions were maintained.	C 325	Please refer to F 371	
C 336	02.108,03,a a. All containers used for storage of garbage and refuse shall be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures, or in a waste refrigerator. This Rule is not met as evidenced by: Please refer to F372 as it relates to the facility's failure to ensure all refuse containers were provided with lids.	C 336	Please refer to F 372	

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C 342	Continued From page 8	C 342		
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F323 as it relates to proper storage of toxic chemicals.	C 342	Please refer to F 323	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it relates to the facility's failure to ensure adequate housekeeping and maintenance services to maintain the interior of the facility.	C 361	Please refer to F 253	
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room	C 393	Please refer to F 246 & F 463	

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C 393	Continued From page 9 shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to accessibility of call lights. Please refer to F463 as it relates to call lights registering a visible signal in the corridor.	C 393		
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please refer to F444 as it relates to the facility's failure to ensure staff demonstrated appropriate handwashing and glove use during direct resident care.	C 669	Please refer to F 444	
C 670	02.150,03,a a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F441 as it relates to the facility's failure to ensure staff demonstrated appropriate infection control measures during direct resident contact.	C 670	Please refer to F 441	
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the	C 696	Please refer to F 250	

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C 696	Continued From page 10 patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F250 as it relates to the facility's failure to ensure residents were provided medically-related social services.	C 696		
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it relates to the facility's failure to ensure services provided met professional standards of quality.	C 745	Please refer to F 281	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it refers to the facility's failure to ensure comprehensive assessments are completed for each resident.	C 779	Please refer to F 272	
C 781	02.200,03,a,iii iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care;	C 781	Please refer to F 279	

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C 781	Continued From page 11 This Rule is not met as evidenced by: Please refer to F279 as it relates to the facility's failure to ensure care plans were developed to meet residents' identified needs based on a comprehensive assessment of the individuals and included measurable objectives and timetables.	C 781		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to the facility's failure to ensure care plans were reviewed and revised to reflect the current status of each resident.	C 782	Please refer to F 280	
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it relates to the facility's failure to ensure care plans were followed.	C 784	Please refer to F 309	
C 785	02.200,03,b,i i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with	C 785	Please refer to F 312	

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C 785	Continued From page 12 patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please refer to F312 as it relates to the facility's failure to ensure residents received necessary assistance with grooming and personal hygiene.	C 785		
C 787	02.200,03,b,iii iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F325 as it relates to the facility's failure to ensure a resident received adequate nutritional intake to prevent weight loss.	C 787	Please refer to F 325	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Pleas refer to F314 as it relates to the facility's failure to ensure residents did not develop pressure ulcers.	C 789	Please refer to F 314	
C 795	02.200,03,b,xi xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Based on observations, staff interview and medical record review, it was determined the	C 795	Please refer to F 315	

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C 795	Continued From page 13 facility did not conduct assessments of incontinence, identify risks for urinary tract infection (UTI), develop and implement care plans timely, and provide approriate during catheter, incontinence and wound care to reduce or prevent UTI. This practice affected 5 of 11 sample residents (#1,2,3,7,8) and resulted in harm to residents #1, 2, 3 and 8. Resident #2 was hospitalized with pyelonephritis on 12/14/05 and with a urinary tract infection on 2/22/06. Between February and June 2006, the resident had 2 additional urinary tract infections. Resident #1 had a history of urosepsis and was hospitalized on 5/17/06 with a urinary tract infection. From December 2005 through June 2006, resident #1 had 4 urinary tract infections. The facility did not assess, care plan or implement a procudure to establish resident #3's continence after removal of a foley catheter. Resident #8 had a supra pubic catheter in place and was at risk for UTIs. The facility did not assess resident #8 at high risk for UTI and had no documented preventative measures in place. Resident #8 was being treated for a urinary tract infection during the survey. Resident #7 had a Foley catheter in place without medical justification. Findings include: 1. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted after being hospitalized for a urinary tract infection on 2/25/06 with diagnoses including Multiple Sclerosis, urinary retention, and history of urinary tract infections and pyelonephritis with stent placement. On 6/6/06, the resident had a suprapubic catheter placed. Prior to that the resident had a Foley catheter in place due to the urinary retention. The most recent MDS, dated 6/08/06,	C 795		

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C 795	Continued From page 14 documented the resident was totally dependent on staff for all cares including toileting, bathing, and personal hygiene. The care plan was not dated but noted an admission date of 2/24/06 and addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the following instructions: "suprapubic catheter. [check] site & apply [unable to read word] until healed. No! Leg Bag!" The care plan did not address the resident's history and risk for UTIs, goals, and interventions for prevention, and did not address routine catheter care. There was no information in the resident's chart regarding a care plan for Foley catheter care prior to the suprapubic insertion in June of 2006. A Resident Care Manager (RCM) was interviewed on 7/28/06 at 11:05 am regarding resident #2 and Foley catheter care. The RCM stated, "...Foley cath care was never put on the care plan..." Nursing notes from 12/05 revealed the following: *12/14/05 at 6:45 am - "Res. [resident] given Dulcolax suppository for bowel care, noted res. [with] pupils fixed & dilated, not answering questions. Moist non-productive cough. T [temperature] 99.8. DK [dark] amber, cloudy urine in BSU [bedside unit]. BS [bowel sounds] very hypoactive, abd [abdomen] firm & distended...O2 [oxygen] SAT [saturation] 82% RA [room air]...order received to send to ER [emergency room]...order received at 4:35 am...res. transferred at 5:00 am..." A discharge summary dated 12/20/05 documented the resident had been admitted to a	C 795		

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C 795	Continued From page 15 local hospital on 12/14/05. At discharge her diagnoses included "pyelonephritis, resolving status post ureteral stent placement December 20, 2005, for right renal obstruction." Nursing Notes from 2/06 revealed the following: *2/16/06 at 11:30 am - "received orders to start Levaquin w/repeat UA [urinalysis] on 3/1/06..." *2/17/06 at 2:15 am - "Continue on ABT [antibiotic] for UTI - urine dark [with] sediments..." *2/20/06 at 7:50 am - "...foley catheter patent of clear yellow urine [with] white sediment..." *2/20/06 @ 10:00 pm - "...ABT therapy for UTI continues [without] adverse reaction - fluids taken poorly - has been heard x3 screaming & crying for no apparent reason..." *2/21/06 at 3:30 am - "Cont. [continues] ABT for UTI...foley catheter patent of clear yellow urine [with] much white sediment..." *2/21/07 at 3:15 pm - "Called to [check] [resident #2]. She was being taken to room. Yelling & cursing. Chin is quivering [illegible word] she denies being cold. Put to bed [with] mechanical lift and applied O2. SATS [saturation] previous to this were 63%. SATS 71% on O2 at 2L/min [liters per minute], [increased] O2 to 3L [liters] but when she relaxed SATS dropped back to 68%...O2 up to 96% on 4L. Turned O2 to 3 1/2L/min. BP [blood pressure] 132/80, P [pulse] 119, R [respirations] 24, T [temperature] 101.9 [degrees Fahrenheit]. Noted Expirational wheezing in [right] lung only. Continues to deny pain...T.C. [telephone call] to [physician] per pager."	C 795		

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C 795	Continued From page 16 *2/21/06 at 3:50 pm - "Received order to transfer to [hospital] ER for evaluation." A History and Physical, dated 2/22/06, documented the resident was admitted to the hospital due to a urinary tract infection and reduced oxygen saturations. Information provided by the facility on 7/31/06 documented the following: *"3/02/06- Urine positive for enterococcus treated with Zosyn changed to Augmentin. Repeat UA order in one week." *"5/03/06- Started antibiotics for UTI this am. Urine clear amber with small blood clots." The physician recapitulation [RECAP] orders, dated July 2006, documented the following orders in regards to catheter care: *"S/P [suprapubic] cath[eter] care Q [each] shift." *"[change] S/P cath q [each] month, place 18 French next time then 20 French after that [and] [with] each catheter change irrigate cath [with] 500 cc [cubic centimeters] GU irrigation [with] each cath [change]." The treatment sheet, dated July 2006, addressed the information contained on the resident's RECAP but did not address specific issues regarding routine catheter care or prevention of urinary tract infections. On 7/28/06 at approximately 11:45 am, the resident was observed during the provision of suprapubic catheter care. The LN was observed to wash her hands and apply gloves before	C 795		

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C 795	Continued From page 17 beginning the resident's care. The LN was observed to remove the old dressing and was not observed to change into clean gloves before continuing catheter care. Wearing contaminated gloves, the LN used a pre-moistened piece of gauze to clean around the stoma site. While cleaning around the stoma site, the LN was observed to wipe towards the stoma site with her gauze as opposed to wiping away from it. The LN used the gauze to dab around the stoma site in a circular fashion. After folding the contaminated portion of the gauze into her gloved hand, she repeated the dabbing motion with a clean portion of the same piece of gauze, again wiping towards the stoma site. When the LN had completed cleansing the site, the LN discarded the contaminated gauze and picked up the clean dressing with her contaminated glove. The LN then applied the dressing to the resident's stoma site. The LN was not observed to cleanse the catheter tubing before applying the clean dressing. According to Nursing Interventions & Clinical Skills (Elkin, Perry, Potter 2000, p. 829), when caring for a suprapubic catheter care and to prevent infection, an LN should: *"Remove old dressing and place dressing and gloves in bag." *"Put on sterile gloves, assess insertion site and patency of catheter." *Maintaining sterility, clean site by swabbing in circular motion starting closest to the catheter site and continuing in outward widening circles for approximately 2 inches (5 cm [centimeters])..." The LN is instructed to perform this step as many times as needed to cleanse the site. The authors	C 795		

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C 795	Continued From page 18 note this procedure "follows principle of sterile technique to move from area of least contamination to area of most contamination....Take one gauze pad moistened in antiseptic solution and cleanse catheter from proximal to distal." An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #2's care plan and the prevention of UTIs. The DON noted that urinary tract infections were common in residents who were catheterized but did not address what the facility had in place regarding preventative measures for residents at risk. The DON and RCMs acknowledged the specific care plan discussed did not address the prevention of UTIs. They noted catheter care was documented on the resident's monthly treatment sheet. The facility failed to appropriately assess a resident who had a history of UTIs and pyelonephritis, identify she was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff failed to practice effective infection control measures during suprapubic catheter care to reduce the risk of infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 2. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The resident had a suprapubic catheter due to a neurogenic bladder.	C 795		

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C 795	Continued From page 19 The most recent MDS, dated 6/5/06, documented the resident was totally dependent on staff for bathing, toileting, and personal hygiene. The care plan, dated 5/23/06, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician RECAP orders, dated July 2006, documented the following orders in regards to the resident's catheter: *5/23/06 "Supra Pubic Cath[eter] care q [every] shift DX [diagnosis]: Neurogenic bladder." *5/23/06 "Change Supra Pubic Cath Q month 20 French w/30 cc balloon." The treatment sheet, dated July 2006, documented "Super [sic] Pubic Cath Care Q Shift" and "Change Super [sic] Pubic Q Month 20 French W/30 CC Balloon." Information provided by the facility on 7/31/06 revealed the following history related to urinary tract infections: *10/19/05 The resident was admitted to the facility following hospitalization for urosepsis. Prior to the hospitalization, the resident had been living at home. *12/07/05 Temperature of 100 [degrees Fahrenheit], bloody drainage from suprapubic catheter. Started on Macrobid and urinalysis (UA)	C 795		

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C 795	Continued From page 20 with culture and sensitivity obtained. The results revealed Escherichia coli (E-coli). *12/22/05 UA obtained due to "SP [suprapubic] trauma with increased temp..." The results revealed Pseudomonas Aeruginosa. *3/9/06 "H & P [history and physical] states urine appears infected with specific gravity > [greater than] 1030, 1+ proteinuria, trace ketones, 3+ occult blood, 3+ leukocyte esterase, + nitrites, 5-10 RBC's [red blood cells], 25-50 WBC [white blood cells], many bacteria, moderate yeast. Impression: Acute sepsis...suspect early sepsis, either from leg wound or from UTI." A physician's note, dated 6/23/06, revealed the resident, "was hospitalized on 5/17/06-5/23/06 for a urinary tract infection with candida albicans." The resident was observed during wound and peri care on 7/25/06 at approximately 11:10 am. The LN washed her hands and donned gloves before cleaning and covering the stage II pressure ulcer on the resident's right ischium. The LN was not observed to wash or sanitize her hands or change her gloves before proceeding to care for the stage IV pressure ulcer on the resident's left ischium. According to documentation, the resident had recently been on isolation precautions due to MRSA infection in the stage IV pressure ulcer. The LN cleansed and covered the wound. During the procedure, she reached into her pocket with her contaminated gloves to pull out a pair of scissors and a sharpie pen. The LN was observed to place the sharpie back into her pocket handling it with her contaminated gloves. After completing wound care, the LN proceeded to assist the CNA in repositioning the resident. The resident had a	C 795		

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C 795	Continued From page 21 bowel movement and required clean up and peri care. The LN was not observed to wash or sanitize her hands after the wound care and before getting herself and the CNA a clean pair of gloves before they began the peri care. During the procedure, a large amount of feces came into contact with the top cover of the resident's air bed. The CNA and LN wiped the area and noted they would change the cover after getting the resident up for lunch in about an hour or so. After completing peri care and dressing the resident in clean clothing, staff were observed to place the resident directly on top of the contaminated area of the air bed with his clean clothing in direct contact with the contaminated surface. An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #1 and #2's care plans and the prevention of UTIs. As stated above, the DON noted that urinary tract infections were common in residents who were catheterized but did not address what the facility had in place regarding prevention measures for residents at risk. The DON and RCMs acknowledged the specific care plans discussed did not address the prevention of UTIs. They noted catheter care was documented on the residents' monthly treatment sheet. When questioned as to what preventative measures the facility was taking to UTIs for resident #1, staff stated they used a leg bag on the resident at times to prevent the catheter tubing from touching the floor and becoming contaminated as well as following facility protocol for suprapubic catheter care. After the interview was concluded, a RCM presented the surveyor with an undated handwritten list that contained the following information: Vitamin C 500 milligrams twice a day, Suprapubic catheter care every shift, using leg bag for catheter when resident is out of bed,	C 795		

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C 795	Continued From page 22 and Minocin 100 milligrams twice a day. According to the resident's physician RECAP, dated July 2006, the resident had been prescribed Minocin on 5/23/06 due to the MRSA infection in his pressure ulcer. The facility failed to appropriately assess a resident who had a history of UTIs and urosepsis, identify he was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff practiced poor infection control during wound and peri care on a resident with known MRSA infection. This failed practice resulted in harm to the resident who was hospitalized in May 2006 with a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 3. Resident #8 was originally admitted to the facility on 1/26/1995, and readmitted on 3/25/04, with diagnoses including paraplegia, schizophrenia, neurogenic bladder, UTI, status post venous thrombosis and cellulitis of the buttocks. The most recent quarterly assessment, dated 5/26/06, documented the resident had severely impaired cognition, was totally dependent for all care and had a suprapubic catheter in place. The care plan, dated 3/25/04, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician's RECAP, dated July 2006,	C 795		

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C 795	Continued From page 23 documented "Supra pubic cath care q shift" and "Change S/P [Suprapubic] cath PRN 18 FR [French]/30CC Balloon DX [diagnosis]: Neurogenic Bladder (Change Q MO [every month]." An order, dated 7/19/06, documented, "7/19/06 Ampicillin 500 mg [one] po [by mouth] BID [twice a day] x 14 days. Dx [diagnosis] UTI." Results of a urine culture, dated 6/29/06, documented the presence of the following organisms: Pseudomonas Aeruginosa, MRSA, and Enterococcus Faecalis. Results of a urine culture, dated 7/13/06, documented the presence of the following organisms: Pseudomonas Aeruginosa and Enterococcus Faecalis. On 7/28/06 at 11:00 am, the surveyor observed a LN change the dressing to a pressure sore on the resident's buttocks. The LN obtained the clean dressings from a cart, placed the clean supplies on the resident's bedside table without cleaning the table or providing a barrier between the clean supplies and the contaminated over bed table. The LN gloved, removed the dressing, cleansed the wound and placed the contaminated dressings on the overbed table. Then, using the hand with the contaminated glove, adjusted the lighting with the light switch and replaced the clean dressing. CMS guidance addresses urinary tract infections and follow up of UTIs as follows: "A long term indwelling catheter (>2 to 4 weeks) increases the chances of having a symptomatic UTI and urosepsis. The incidence of bacteremia is 40 times greater in individuals with a long term indwelling catheter than in those without one...Recurrent symptomatic UTIs in a	C 795		

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C 795	Continued From page 24 catheterized or noncatherized individual should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling in accordance with accepted practices...to re-evaluate the techniques being used for perineal hygiene and catheter care...the facility should demonstrate that they: Employ standard infection control practices in managing catheters and associated drainage system; Strive to keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder...; Assess for fluid needs and implement a fluid management program...based on those assessed needs." The facility failed to identify residents at risk for UTIs, develop care plans addressing preventative measures and demonstrate appropriate infection control practices during wound and catheter care. 4. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke] hematoma of left leg, sacral stenosis, and dementia. At the time of admission, the resident had a Foley catheter in place. The catheter was discontinued on 5/1/06 per documentation in nursing notes. An MDS, dated 5/9/06, documented the resident was severely impaired in cognition, was totally dependent on staff for most ADLs including toilet use and that she was frequently incontinent of urine. An "Assessment for Bowel & Bladder Training" dated 4/28/06, documented the following in the "Bladder Continence Pattern" section: "N/A [not applicable]" and the box "Frequently incontinent (daily with some control)" was marked. The form noted the resident had a Foley catheter that had	C 795		

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C 795	Continued From page 25	C 795		

been inserted on 4/23/06. The "Symptoms", "Evaluation", "History", and "Plan for Management" sections of the form were left blank.

The care plan was not dated but documented an admission date of 4/28/06. The care plan addressed toileting in problem 1, "ADL/REHAB" and documented the resident was incontinent of bowel and urine and had a Foley catheter in place. One portion of the care plan that was undated documented the resident "pulls on catheter tubing" and had a "UTI."

An "Assessment Summary", dated 5/11/06, documented "Res[ident] toilets [with] assist of 2 [and] is dependent for peri care, proceed to care plan."

An interview was conducted with the DON and 3 RCMs on 7/27/06 at 12:35 pm. The DON acknowledged a bladder assessment had not been completed on the resident after the catheter was removed on 5/1/06. She stated that she would have to look at OT (Occupational Therapy) notes as that was within their scope of practice and they should have assessed her. She stated, "...[the resident] resists a lot, [the resident] is very demented..." She acknowledged the facility did not assess the voiding patterns of the resident.

The DON was interviewed again on 7/27/06 at 3:10 pm , regarding an updated bladder assessment. She stated, "We did assess, we just didn't re-assess after the Foley was removed." She indicated the resident was incontinent due to dementia and stated that if the facility toileted everyone, they wouldn't have time for other cares.

The facility did not ensure a resident was

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C 795	Continued From page 26 accurately assessed regarding urinary incontinence to ensure she received the appropriate services to restore or improve normal bladder function to the extent possible. The resident was not re-assessed after her Foley catheter was removed 3 days after she was admitted to the facility. The facility had no documentation on the bladder assessment referencing the resident's prior history of incontinence, voiding patterns, medication review in reference to incontinence, patterns of fluid intake, or other comprehensive assessment information pertinent to urinary incontinence. The resident was not care planned for a specific toileting program for the prevention of urinary tract infections related to incontinence issues. The resident was assessed as incontinent per the MDS of 5/9/06 and documentation from the July "CNA Flow Sheet..." indicated she was incontinent at the time of the survey. 5. Resident #7 was admitted to the facility on 7/21/06 with the diagnoses of squamous cell tongue cancer, hypothyroidism, chronic aspiration, stage III pressure ulcer, fractured femur, and aspiration pneumonia. An "Admission Nursing Assessment", dated 7/21/06, documented under abdomen/bowel/bladder, "Foley: Size/Type & Dx [diagnoses] for use Fx [fractured] hip. Dr [doctor] to remove in one week." A transfer physician order dated 7/13/06 documented, "Discontinue Foley per [physician name] at follow-up appointment..." Resident #7's current care plan documented that the resident had a commode at his bedside.	C 795		

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C 795	Continued From page 27 Resident #7's CNA flow sheets for July documented that the resident used the bed side commode for toileting. On 7/27/06 at 3:15 pm, resident #7 was interviewed. He indicated with the motion of his head and his hands that he used his bed side commode for bowel movements. On 7/26/06 at 9:05 am, the DON indicated that resident #7 was admitted with a Foley catheter and and was not sure why it was in place but would find out and let the surveyor know. Several hours later the DNS provided the surveyor with a physician telephone order. A physician's telephone order dated 7/26/06 documented, "Foley catheter indicated r/t [related to] hypoxia [and] respiratory distress [with] exertion..." Resident #7 was admitted with a Foley catheter and there was no documentation indicating any medical condition that warranted the continued use of an indwelling catheter. The facility failed to ensure that a resident with a catheter was assessed and evaluated to determine the need for the catheter.	C 795		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F514 as it relates to the facility's	C 881	Please refer to F 514	

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C 881	Continued From page 28 failure to ensure resident records were complete and accurate.	C 881		